MGP TECHNICAL CONFERENCE FOR VISAYAS

Theme: Improving Access to Family Planning Services

HIGHLIGHTS OF PROCEEDINGS

November 26 – 27, 2002
Waterfront Hotel
Cebu City

Management Sciences for Health
Philippines Program Management Technical Assistance Team Services (PMTAT)
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Plenary : November 26, 2002

Opening Ceremonies

The MGP Technical Conference for Visayas formally opened with some words from the Conference Facilitator, Ms. Eireen Villa. She indicated that the acronym MGP should stand for mag-sharing, makining at magtanong, makialam at makigaya in the collective sharing of good points and practices observed in the implementation of the Matching Grant Program in the Visayas.

Invocations were led by Atty. Ramon Maceren, followed by the singing of the Philippine National Anthem.

Welcome Remarks
Dr. Rosario Marilyn Benabaye
Regional Director, CHD Western Visayas

Dr. Benabaye welcomed the participants to the Conference. In 1998, DOH implemented the MGP that aims to strengthen partnerships between the Department of Health (DOH) and Local Government Units (LGUs) to expand the quality of family planning (FP, maternal-child health (MCH) and nutrition services. This development enabled LGUs to carry out innovations and creative strategies to increase coverage, making the services available to the marginalized sector. This Conference gives the participants the opportunity to share knowledge and experiences. It is hoped that success stories and alternative strategies that will be shared will lead to replication and adoption.

Acknowledgment of Participants
Dr. Jose Rodriguez
Chief of Party, Management Sciences for Health

The participants were formally acknowledged by Dr. Jose Rodriguez, who was assisted by the Regional Directors of Regions VI, VII, and VIII.

Message
Hon. Milagros Fernandez
Undersecretary, Department of Health

This is the second in a series of conferences on MGP, made possible thru the technical assistance of Management Sciences for Health (MSH) and the United States Agency for International Development (USAID). Undersecretary Fernandez conveyed the message of Secretary Manuel Dayrit who could not come due to the budget hearing on health.

The DOH national program marked a turnaround in the choice of priority programs for implementation, considering problems encountered and the limitation of funds. The six programs that were prioritized included: one, Child Health under which falls the epidemiological program, food fortification that advocated for the household and consumer-wide utilization of iodized salt and micronutrients, and the promotion of Vitamin A. Two, Women's Health covering maternal health implemented through the 10-point RH program, the critical element of which are FP and MCH. These programs are funded by the MGP. Three, Tuberculosis Ccontrol that aims to eliminate the disease by 2004 through the intensification of the Direct Observed Treatment, Short Course Therapy or DOTS. Four, Lifestyle Diseases under which fall the anti-smoking campaign that prevails upon LGUs to legislate ordinances preventing smoking in public places like hotels and theaters (i.e., Makati City, Davao City). Five, GMA-50 or *Gamot na Mabisa at Abot Kaya* that involves the sale of low cost quality drugs in selected hospitals that will be followed by the provision of low cost drugs under the Parallel Drug Importation Scheme for devolved provincial hospitals. And six, the Social Health Insurance Program that aims to cover all indigent families. This program has now exceeded its target of 500,000 families, having insured more than 1 million of the population under PhilHealth.

The programs are implemented under the larger umbrella of the Health Sector Reform (HSR) Agenda, a bold direction taken by the DOH and the Government of the Philippines as well as countries worldwide for the purpose of bringing about efficient and effective health systems and services. The HSR covers five reform areas in hospitals, enabling them to enjoy greater fiscal autonomy. The

first area is income generation that enables the hospitals to realize income to support operations, thereby providing indigents with greater health access through social insurance; second, under the HSR, a multi-year budget is provided for the control of TB, malaria, measles, and schistosomiasis; the third reform area is local health systems where the strategy of establishing inter-local health zones is operationalized. These zones are called by different names and are, in essence, a revival of the district health system prior to devolution. Under this concept, a hospital will be equipped as a core referral hospital for catchment service areas where resources can be maximized with the aid of cost-sharing schemes observed throughout the network.

The fourth area of reform is regulation, mainly involving food and drug administration. Mini-BFADS (Bureau of Food and Drugs) have been installed in Cebu and Davao. Once these mini-BFADS are operational, there will be a better a regulatory system for the registration of drugs and processed foods. Herein falls the enforcement of local ordinances related to the *Asin* Law, Generics Act, others. The last reform area is Health Care Financing under PhilHealth, envisioning to cover all indigents under the universal insurance concept.

The MGP, supported by USAID and MSH, underscores the efficient utilization of funds. Grants are channeled to the Municipal / City Health Departments that should be able to develop their respective expertise in the utilization of the funds. Health programs include MCH, FP/RH and Nutrition. The grant cannot be used for personnel services or hiring purposes. But it can be used to procure medical supplies and equipment essential to the programs. In Region VII, LGUs are encouraged to purchase RH and FP commodities inasmuch as the central government through the DOH can no longer use funds to buy contraceptives. LGU initiatives to procure essential contraceptives or drugs and medicines for Voluntary Surgical Sterilization (VSS) are, therefore, encouraged.

A counterpart program exists under MGP that may be used for *Sentrong Sigla* (SS) certification, and for upgrading rural health units to become SS-certified via renovations or the purchase of operating equipment. The grant may also be used to enroll indigents under the Indigent Program. For LGUs with existing SS facilities, counterpart funds can be used to work out the SS-certification of other facilities and for other priority programs approved by the CHD. Unutilized grant funds can be reprogrammed for activities to sustain the coverage targets for MCH, FP and Nutrition. LGUs that fail to meet targets should be able to initiate other strategies to meet their targets.

What then are the grounds for the suspension or termination of the MGP? An LGU can be terminated if one, they opt to terminate during program implementation; two, if LGUs are not interested to renew; three, non-compliance with the provisions of the Memorandum of Agreement with CHD-DOH; and

four, the CHD can opt to deny enrollment, and recommend renewal or non-participation in MGP.

Undersecretary Fernandez wished the participants a fruitful conference. The DOH will be open to all issues and concerns that may crop up in the sharing of best practices. The practices should be reflected upon for possible replication in other areas.

Presentations :

1. Highlights of the 2001 Family Planning/Maternal-Child Health Surveys
Ms. Charito S. Doller
National Statistics Office-Region VII

The 2001 FP/Survey was a nationwide survey conducted in tandem with the Labor Force Survey involving interviews with female members of sample households. It is the sixth in a series of surveys conducted from 1995 to 2002, with funding from the USAID. Some of the broad objectives were to provide statistical information on the Contraceptive Prevalence Rate (CPR) and to provide planners with the vital information they needed to monitor changes in FP practices.

A total of 20,036 households and 32,035 women were interviewed. The response rate was 94.1 percent. The CPR increased to 29.5 percent in 2001 from the previous year. The prevalence rate of modern methods increased constantly. In terms of method mix, 50.5 percent declared no method use. The pill registered 14.1, female sterilization and periodic abstinence posted 10.5, and others, 14.5 percent. Pill users increased from 1993 to 2001. The CPR varied by age group, peaking from 35 to 39 years, whereas it was lowest at ages 15-19. CPR peaked at ages 35-39 years. The three most preferred and popular methods were pills, female sterilization, and the calendar or rhythm method.

From 1995 to 1998, CPR was highest in Region 11 or Southern Mindanao. From 1999 to 2001, Cagayan Valley or Region II posted the highest CPR. The pill is commonly used in the Ilocos, Cagayan, Southern Tagalog, Western / Northern / Southern Mindanao, NCR and CARAGA Regions. Female sterilization is a favorite in CAR, Central Luzon, NCR and Southern Tagalog regions. Traditional rhythm was widely practiced in the Bicol, Visayan and Central Mindanao regions. In terms of occupational practice, those in service and sales jobs posted the highest CPR.

CPR and method mix varied by socio-economic status, with households being classified either as poor or non-poor. The CPR was higher among the non-poor households. The pill was the most popular method among poor and non-poor alike. Female sterilization was also very popular among non-poor households. The public sector was the major source of supply, posting a service percentage rate of 72.8 percent. The private sector accounted for 26 percent of supplies. Wanting a child was the oft cited reason for not wanting contraception.

Meanwhile, the 2001 MCH Survey was conducted also with funding from the USAID. It sought to find out the percentage of women who received pre-natal and post-partum care and the number of children who were immunized. Some 8,218 households and 8,439 women were interviewed. Some 4,525 women received pre-natal care nationwide, representing a national level of 94.6 percent. Of these women, 63.3 percent availed of the services of nurses and midwives. Six out of ten or 64.5 percent of women with surviving children below three sought for post-natal care. The national figure for post-natal care stands at 64.5 percent. The biggest post-natal care providers were doctors.

The percentage of children protected against neonatal tetanus was 55.6. The number of children who were fully immunized (FIC) totaled 61.3 million, 66.9 percent of whom are in urban areas, and 56.5 in rural areas. In terms of micronutrient supplementation, the national percentage of children 6 months to 5 years who received supplementation was 75.6 for Vitamin A,57.8 for Iodine, and 68.2 for iron.

Issues and Concerns

Mechanics of the iodine supplementation. A survey was carried out on household women aged 15 to 49. The data relied on mothers who supplied pertinent information on iodine and Vitamin A supplementation.

Reason behind significant drop in immunization ratings in Western Visayas. Reason was the irregular supply of vaccines, hence the reduction in performance for FIC. Procurement needs were previously met by the UNICEF. The DOH attempted to procure as a cost-saving measure, but the UNICEF charged an administrative cost. There were bidding problems that affected other regions as well.

Social insurance coverage for indigents unable to procure medicines from hospitals. The problem is being addressed by Secretary Dayrit who chairs the PhilHealth Board. The complaint is that cards are not serviceable to indigents. The PHIC is doing its best to solve the system mechanics. Hospitals will also be upgraded to serve indigents. Representations can be made by DOH and Mayors to

address concerns relative to the payment of premiums i.e., making it retroactive. *(Mayors present were asked to confer with Undersecretary Fernandez on the matter.)*

Resistance from religious organizations. Advocacy has been initiated in the area of Family Planning. Inasmuch as the concern is religious in nature, gentle persuasion is employed. The strategy is to ask recipients to exercise free choice in the methods they want to use. Undersecretary Fernandez informed that the question pertains to immunization, not FP. There are many ways of encouraging religious cults to join the program. In South Cotabato where tribal/religious groups reside, the LGU employed educated people in these tribes to join the health sector. Secondly, medical outreach teams were sent to critical areas, equipped with food assistance from DSWD that served as incentives to the cultural communities to come down and avail of health services. It takes an innovative strategy to gain the support of religious groups. Attract them with the pluses of preventive health programs. LGUs will have to use their creativity.

2. The New Family Planning Policy

Dr. Honorata L. Catibog
Director, Center for Family Health

The Philippine Government aligns its policies with the goal of putting people at the center of development. The DOH established the Reproductive Health (RH) Program in 1998 to provide universal access to quality RH services, one critical element of which is FP. DOH has set population and development (PopDev) and FP as priority interventions in its vision of Health for All, with the view of attaining quality of life for all Filipinos with special focus on the poor. FP therefore refocuses from demographics to health intervention, with special attention to improving the health status of women and children.

Administrative Order 50-A series of 2001 directs all government institutions to provide FP services and make information available to men and women needing services. These include natural FP, pills, condoms, injectables, IUD, and VSS that shall be promoted based on the health intervention initiative. Services will strive to address unmet needs and demands of women, delivered with respect to the sanctity of human life, human rights, and the rights of clients.

The current situationer is that there are at present 80 million Filipinos, representing the 14th largest population in the world, with a growth rate of 2.36 percent that is expected to double in 29 years. Forty percent of this population live in poverty. There is a one child gap between desired and actual family size. There are 1.1 million women who want to stop giving births, while one out of six

pregnancies end up in abortion. There are teen age pregnancies that account for 30 percent of all births. Twenty-one percent of these children are illegitimate.

AO 50-A series of 2001 reflects the government's FP Policy, four basic strategies of which are FP itinerant teams, FP for the urban poor, mainstreaming NFP, and strengthening FP in regions with the lowest CPR and highest unmet needs.
The goal is to expand the Community-Based Monitoring and Information System (CBMIS) to non-MGP areas, identify clients in need of FP methods, master listing potential sectors and segmenting clients, and enabling the participation of frontline hospitals. DOH-retained hospitals are tasked to create FP itinerant teams. FP should be made to become part of medical and surgical outreach missions with the requisite budget for the teams and missions. The hospitals are also expected to form partnerships with LGU hospitals.

The concept of home service is being explored for the delivery of FP services to urban and rural poor. Under the Contraceptive Interdependence Initiative Action Agenda, market segmentation will be pursued through the increase in PhilHealth coverage, LGU financing and cost sharing, involvement of the private medical sector, and the provision of national funding/subsidy. The FP action agenda will, in turn, be based on coalition building, capacity enhancement, strengthening service networks, and the prioritization of FP as part of the development agenda of LGUs.

Problems that may be encountered in the program lie in the areas of managing the opposition. This can be addressed by intensifying private sector involvement, preparation of contingency measures, and development of allies to serve as program champions and movers

Issues and Concerns

Promotion of NSV in RHUs instead of hospitals since the hospital setting may impose another limitation/ barrier. The itinerant setting need not be in hospitals. No-scalpel vasectomy can be done in less formal places like RHUs and Barangay Health Stations. The role of the hospital is merely organizing the team, whose members are adequately trained in surgical procedures.

Dr. Roquero added that the intention of NSV is to develop the capacities of hospitals already equipped with skills for mini-lap under local anesthesia. Under the OB-Gyne residency program, this has become a standard requirement (40 cases) for graduation. Hospitals' NSV capacity has not yet come about. We should reinforce hospital residency training. One exploratory case in point is the Cebu Urology Department, where one of the activities is men's RH. NSV can be

done in simpler settings at health center level as long as it complies with the requirements of the department for clinics.

Identification of itinerant team members should be based not only on the basis of training, but also on skill and experience. We have just started training in NSV. IT teams will not necessarily be composed of hospital personnel but also those coming from the RHUs. Training will be conducted with MSH assistance and in coordination with DOH. There are local training initiatives, in Southern Leyte. With further training, we will have more access.

Dr. Roquero added that the concern is developing capacities-how to turn out a constant supply of surgeons skilled in NSV and mini lap. We cannot ensure beyond graduation that they will do the procedures. We know that by the time they go rural, there will be available capabilities there. The reality in settings outside hospitals is that there is limited access to competent anesthesiologists. We are removing this barrier. The same goes for no-scalpel vasectomy. These are strategies to address the need for the non-supply of basic anesthetics.

Cut-off in contraceptive commodity supplies. USAID will reduce pill supply by 30 percent effective 2003. DOH is identifying alternative sources of commodities. The possibility of tapping the United Nations Population Fund (UNFPA) is being explored to maintain supplies until 2004. In the next two years, there will still be adequate supply. Dr. Catibog clarified that a portion of the budget for family health and safe motherhood will be earmarked for FP. Papers have been signed for distribution of surgical and medical supplies to different regions. The Central Office will issue communications to this effect. The volume of commodities will be based on the requests forwarded to the Central Office.

Religious convictions/ leanings of doctors performing VSS. The national FP policy is premised on respect for sanctity of life, human rights, freedom of choice and voluntary decisions, and the right of clients to determine family size. Under these principles, client rights are well respected as well as their religious beliefs.

Dr. Roquero informed that the biggest barrier is that imposed by providers themselves. Personal beliefs should not be imposed on the client. Your role is to provide the service, this is the vow of government to respond to unmet needs. We should serve that urgency, we have lost that urgency in FP. The obligation is to meet to the need.

On Marie Stopes. Undersecretary Fernandez informed that Marie Stopes is doing great work in FP but they did not seek DOH permit to operate. Since it has been accredited with the necessary permit and license, they resumed on the condition that tubal ligation will be performed in a hospital setting to protect the patient.

Inclusion of DOH plans in national budget provisions. In one national staff meeting, the Secretary explicitly stated that he has no political plans whatsoever, but will serve in his capacity as DOH head. Regarding the budget provision, FP is under the family health cluster. Before the budget is presented to Congress, there is an internal budget committee hearing at DOH level. The needs of the different programs are analyzed. One of the hardest hit is DOH which stands to suffer a cut of PhP1 billion, affecting all programs. As to provisions for FP, one of the strategies was to divide the market into segments and bat for LGU/private sector support. DOH cannot answer for all FP needs, it needs partners from various sectors.

How to manage demand that exceed supplies and use of MGP funds for the purpose. In the case of diminishing support from foreign donors, the fallback for DOH and LGUs is to establish coordinative links, networking, and partnerships. MGP can partially provide the answer; and so will contraceptive interdependence initiatives, and PhilHealth subsidy to cover surgical procedures and commodities for outpatients. Other ways are the LGU cost-recovery program for FP supplies under the social costing concept, networking with NGOs, and national funding of LGUs.

Mr. Despabiladeras announced that the USAID shall shift support from contraceptive procurement to assistance for other FP services. It has provided contraceptives since the ’70s, and 32 years is too long a time to be providing a bulk form of assistance. The situation cannot continue for long. This November, the last shipment of condoms will arrive after which no more can be expected; but the supply can last for 2003. Next year, pill shipments will be reduced. DOH has asked UNFPA to provide pills. Whatever quantity will be provided by UNFPA will also be deducted accordingly from USAID assistance. In 2004, there will be reductions in IUDs and DMPA. USAID is just responding to an agreement with government in 2000 in which there was a pledge from the Philippine Government to buy commodities for the FP program. In 2001, there were moves to purchase pills but this was overtaken by changes. Since the DBM will not release funds for this purpose, the commodities that will be made available will not be sufficient for everybody. But commitments so far will be reserved mostly for indigents. Therefore, the need for market segmentation in selected provinces, e.g., Pangasinan. This can provide lessons on how LGUs can identify clients. This Conference is the proper forum to discuss the subject.

3. Updates on Sentrong Sigla Certification Program
Hon. Milagros Fernandez
Undersecretary, DOH

Based on evaluation or analysis of *Sentrong Sigla* standards, we felt the need to improve them. The improved standards were developed with multi-sector involvement. Basic standards became comprehensive and stable, including total quality in input, process, and outcome indicators. The SS is limited to public health facilities, while PHIC standards will be applied to hospitals.

The four main areas of focus are one, core public health services; two, facility and environment systems focusing on plans, MIS, HRD, etc.; three, regulatory services, such as compliance with the Sanitation Code, the *Asin* Law, Milk Code, Generics, ordinances, etc.; and four, basic curative care services – whether focus has been given to outpatient and emergency care services.

Improved SS processes and procedures is indicative of the involvement or wider participation of stakeholders. The Technical Assistance Committee extends a purposive kind of technical assistance that identifies priorities such as improved supervision at the facility level, enhanced monitoring, etc. There are three levels of certification, namely, Basic Certification for Level 1; Specialty Awards for Level 2 Certification, and Award for Excellence for Level 3.

Ongoing activities under the SS program include the field testing of standards and assessment of selected sites nationwide in November 2002, organization of Regional Technical Assistance and Assessment Teams by CHDs in the 1st Quarter of 2003, orientation of the teams within the same period, and the training of Regional Assessors by the 1st to the 2nd quarters of 2003.

Issues and Concerns

On failure to receive SS certification awards, i.e., study tours. Undersecretary Fernandez informed that the Asian tour may have been conceived by persons who did not continue in service after the Estrada administration, but was not translated into a budget provision. We only knew about the PhP1M. Dr. Benabaye can make a recommendation. A tour can be organized which will not have an age limit.

On TB DOTS: potential danger of inadequate supply of TB medicines and supplies that could lead to the development of drug-resistant cases in Iloilo, which was identified as a site for public-private mix. Undersecretary Fernandez

informed that this will be brought to the attention of the Central Office. There was a delay in the procurement of TB drugs, but supplies were already purchased.

Hazard allowance for public health doctors exposed to TB bacilli. USEC Fernandez informed that the Magna Carta Consultative Council could address problems pertinent to Magna Carta provisions. DBM has informed that the budget for the purpose has been given to LGUs. Secretary Emilia Boncodin stated that LGUs can be encouraged to pay. DOH is lobbying for LGUs to appropriate in their local budgets a lump sum for Magna Carta benefits. At a Congressional hearing, Rep. Satur Ocampo asked the House to include Magna Carta in LGU budgets.

Possibility of DOH providing counterpart for the LGUs' drug supply. The Department cannot do this due to accounting principles.

Problems in IRA cut that hinder LGUs from allocating funds for health services. Undersecretary Fernandez explained that there is a lump sum amount in the budget of local governments, the payment for Magna Carta benefits.

DOH role in helping LGUs attain Sentrong Sigla status. Provinces could provide technical assistance to the municipalities through the Regional Technical Assistance Team (RTAT) that should include personnel from the PHO.

DOH budget of PhP50 Million for NFP mainstreaming. LGUs can submit a project plan for NFP and submit this to the Region that shall, in turn forward it to the Office concerned.

Doctors taking up nursing careers. This has been discussed by the DOH Execom. The problem also concerns the local nursing profession. By 2010, we will have no more trained nurses. The Secretary created a committee to study the matter. Many nationalities come to take up nursing here and leave without giving something back in terms of the training they received. This worsens the state of our economy.

Concurrent Sessions: November 26, 2002

CONCURRENT SESSION I
EXPANDING FAMILY PLANNING SERVICE DELIVERY

Highlights of Presentations

1. Meeting Family Planning / Reproductive Health Needs Through Better Planning and Financing
Dr. Aurora Perez
The Futures Group International

Typical of local governments of most Philippine communities, the municipal government of Tanjay had limited resources for Family Planning/Reproductive Health (FP/RH). It had to contend with political parties and sectors that espoused conflicting views on FP and RH. As a result, Tanjaynons were generally barely aware of RH as a human right.

Against this backdrop, the POLICY Project of the Futures Group International, in partnership with the Population Commission, PLCPD, Philippine Non-Government Organizations Council, the United States Agency for International Development and the Tanjay City government, organized a Municipal Advocacy Team (MAT). The MAT is an inter-agency mechanism aimed at mainstreaming participatory approaches in policy making processes at the local level. It was intent on forming effective public-private sector partnerships in the interest of FP/RH, and encouraging resource pooling among these partners.

Tanjay had all the properties of an indicative site for the FP/RH program. It showed the greatest potential for creating impact on the community, and had structures already in place for service delivery and responding to unmet needs. The most important consideration was the inclination of local government leaders to make way for FP/RH as a program that would benefit their constituency.

The Advocacy Training Manual enabled MAT group members to identify and establish an informal network within and outside the team. Relationships were built not only with the administration officials but with the opposition parties as well. The project essentially banked on the principle of "*Kamag-anak kita, kapamilya kita network*" (friends / family network).

Eight months later, the MAT has achieved modest success. Innovative resource generation schemes have been formulated. Public-private partnerships in advocacy and in the promotion of FP/RH programs were enhanced. Presently, there are church representatives in the MAT who attend meetings and offer suggestions on how the various church groups can assist the team. One of the result areas between MAT team and the religious sector was the agreement on the counseling of adolescents. Together, the partners prepared the syllabus for adolescent counseling. They also advocated for the conduct of pre-marriage counseling as a requirement to the application for marriage licenses, which was, in turn, implemented by the LGU. In this manner, the desired consultative process was institutionalized.

Aside from courting multi-sectoral involvement, additional LGU resources have been allocated to the program.

The MAT was able to contribute significantly to local planning and financing in support of local FP/RH concerns. To ensure sustainability, the municipality plans to invest more resources in training and development of the MAT team members, so that they could influence neighboring municipalities and replicate the program in other venues.

Issues and Concerns

Church's stand on FP. Church representatives attend MAT meetings and give suggestions on how the church groups can contribute to the cause. One of the partnerships between MAT and the church is the agreement on adolescent counseling, for which a joint syllabus was prepared. Another area of collaboration is pre-marriage counseling.

Criteria for site selection. Criteria included population size, potential impact, structures in place, service delivery system, level of unmet needs, and LCE attitude on FP / RH. For sustainability, the idea was to train and invest in the human resource development of MAT team members.

Political color in project identification. Advocacy training involved skills transfer to the MAT core group so they could identify and establish an informal network. Relationships are made not only with the present administration but also with the opposition. The project banks on the principle of "*Kamag-anak kita, kapamilya kita network*" (friends and family connections) at work in the project sites. The support of people's organizations was needed. In Sorsogon, the project was started by the previous Mayor and passed on to the next. Informal gatherings were important for the MAT since they served to strengthen bonds.

2. Linking CBMIS with Service Delivery: Continuing Role of the Provincial Health Office in Family Planning
Ms. Celia Fuentebaja, RN
Negros Occidental

The presentation revolved around the Negros Occidental Provincial Health Office's continued commitment to support and implement the Family Planning Program. As a whole, the PHO envisions a healthy life for all Negrenses, and seeks to achieve this through the provision of quality health care through affordable and sustainable delivery system. It also sought to promote health through the development and use of appropriate technology.

Negros Occidental availed of the LPP assistance from 1995 to 2000 to strengthen the LGU's capability to manage health programs with emphasis on FP. From 1999 to 2001, the province sub-granted a portion of the LPP funds to selected LGUs on the basis of performance benchmarks, income classification, and expressed commitment. The Center for Health Development in Region VI followed through with another grant in 2002.

The PHO offers the following technical assistance packages to deserving LGUs. It organized training for personnel in CBMIS and quality assurance. This enabled the LGUs to meet Sentrong Sigla standards for FP/RH. BHWs were also trained on counseling, client motivation, IEC, and the health referral system. The Competency-Based Training Manual on Inter-Personal Communication Skills (IPC) was used to enhance their capabilities. The PHO has trained a total of 343 BHWs to date.

The PHO aims to continuously assist MGP LGUs in meeting program benchmarks, particularly for contraceptive prevalence rate for modern methods. To fast-track training of BHWs, the PHO intends to adopt a cluster approach. A pool of MGP-LGU trainers divided by health zones will render mutual assistance during the conduct of training. It also plans to identify and help set up training sites for NSV in the northern and southern parts of the province.

Issues and Concerns

USAID funds for BHW honoraria. Dr. Catibog of DOH informed that one measure currently being proposed by Speaker de Venecia is to give a package of non-monetary benefits for BHWs (e.g. scholarships, free medical services). Different LGUs can provide their own package of benefits, depending on their capability. If the poorer LGUs cannot assist their BHWs, they can ask for the

support of the provincial or national governments. There could be problems in the provision of such benefits, e.g. political interference.
Mr. Despabiladeras of USAID explained that agency funds cannot be used for personnel services but may be utilized for supplies, equipment, training, MIS, and research.

BHW expanded training program results. There has been a significant increase in the turn-out of would-be clients for ligation and NSV. Based on experience, the training of BHWs has helped in motivation, IEC, referrals, re-supply, and the recruitment of acceptors especially for the surgical methods.

BHW training on CBT and pre-counseling where the expectation was for BHWs to dispense the initial prescription of pills. BHWs are not allowed to dispense the initial dose of pills but only to re-supply. The initial supply is done by the health center and the final decision rests on the medical service provider/ nurse/ midwife. Although this was part of the training agreement, DOH guidelines are still being awaited.

In this connection, MSH has contracted the UP National Institute for Health to do an operations study. If there are agreements on the process of dispensing the initial supply of pills, it should only be implemented after completion of the study. Only then can it be determined whether BHWs may be allowed to proceed with the initial dispensing of pills using the checklist.

Focus of FP counseling. Despite training, service providers are still handicapped in explaining FP technologies. It is not called counseling but a strategy to reach service providers to motivate, educate, and to provide information on FP methods. BHWs are constantly reminded of their role and the need to expand their working knowledge. Should clients need more information, BHWs should refer them to the midwives.

3. Through Sub-grants and Grants: Sustaining Family Planning-Focused Approaches

Dr. Erwina Jalandoni
La Carlota City, Negros Occidental

La Carlota City is a third-class city with a population of 60,000. It has a sugar-based economy with a peak and a lean month season. With a land area of only 13,729 hectares, the city has the smallest internal revenue fund allocation in Negros Occidental. In 2000, it received a grant from the LPP. The grant was used to develop its main health center, FP clinic, and two satellite FP clinics. One of the FP clinics is located in a mountainous barangay. The LGU counterpart for this grant was the construction of the main health center's FP clinic. Another

grant was received in 2001 which used to purchase medical and surgical supplies for voluntary surgical sterilization. For 2002, another grant was received from the CHD to sustain FP services in the city.

With the infusion of additional funds from MGP, the City Health Office (CHO) was able to link with the Provincial Health Office and hold several activities together. One such activity was the training of BHWs. As frontline health workers, the BHWs went through a seminar to hone their skills in FP counseling and in handling other reproductive health issues.

Another strategy employed by the CHO to reach the grassroots level was the strengthening of the FP itinerant team. Aside from handling IUD insertions, the FP itinerant team has been able to extend regular pap smear examination services. Previous to this, women from the low-income group could not avail of regular pap smear examinations because of the cost. With the MGP funds, the CHO was able to shoulder the cost of supplies. Furthermore, awareness of the need to undergo such medical tests was very low at the barangay level.

The CHO was also able to forge a partnership with another non-government organization, Marie Stopes of Mandaue, Cebu. Marie Stopes sent a team to assist the CHO staff in servicing clients who opted for voluntary surgical sterilization. The LGU was able to tap the business sector to provide food and transportation to those who went through voluntary sterilization. Some employers also encouraged their employees and workers to submit to sterilization. In the ensuing discussions, it was announced that Marie Stopes has complied with the DOH requirements to operate and their cooperation may be sought in underserved areas. The venue for the performance of a VSS, however, should be a facility duly accredited by the DOH, to comply with sanitation and sterilization standards. In MOAs entered into between LGUs and organizations like Marie Stopes, the responsibility for complications arising from the procedures should be borne by the service providers.

The LGU and the community are now united in the effort to support institutionalization of the quarterly ligation schedule and to link with EngenderHealth for training of an MHC physician in No-Scalpel Vasectomy. The CHO, as part of its *Sentrong Sigla* commitment, is strengthening the capabilities of eight more Barangay Health Stations (BHSs) IUD services provisions.

Issues and Concerns

Private sector involvement. The private sector was tapped to provide food and transportation to clients of VSS. Some employers also helped out by encouraging their workers to submit to the procedure.

Relationship with Marie Stopes. Marie Stopes reimbursed the medical costs. Everything went fine with the first activity. There was one complication but it was managed. Under the MOA signed with them, the venue, supplies and medicines were to be provided by the City Health Office. Marie Stopes would take charge of the equipment and expertise. The MOA was clear on the issue that any complication arising from the surgery shall become the sole responsibility of Marie Stopes. Support was provided by the BHWs in the recovery phase.

Liability issues concerning Marie Stopes. At the Plenary of this Conference, USec. Milagros Fernandez announced that Marie Stopes has already complied with the requirements for a permit to operate.

Pertinent to the requirement that VSS procedures should be done in duly-accredited health centers, sanitation standards were brought to the attention of Marie Stopes. Representatives were sent to the facility a week before the operation. They taught the staff set-up and sanitizing techniques. The health center site was the former district hospital.

Need for Health Center accreditation. The local government of La Carlota has expressed full support to the undertaking. Different localities require different strategies. For La Carlota, this set-up is appropriate and functional.

Activities of the FP Itinerant Team. Team activities include pap smear examination for the poor, IUD insertions, and counseling.

4. Improving Access to IUD Services: The Bago City Experience

Ms. Daisy Enriquez, R.N.
Bago City, Negros Occidental

Bago City in Negros Occidental is located 22 kilometers south of Bacolod City. It has a total population of 145, 946 and is divided into 24 barangays. Health facilities include a city hospital, 3 main health centers and 32 barangay health stations. It has been a Matching Grant Program partner since 1999, with ten out of 24 barangays prioritized as MGP sites. A total of 23 midwives cover ten (10) MGP priority barangays. Of these midwives, eight were trained in comprehensive FP. However, only four of them are actively performing IUD insertion. The inactive RHMs and their barangays were made pilot areas for the IUD strategy.

The City Health Office utilized several strategies to address the FP and RH concerns in the locality. As an MGP site, the city maintains a Community-Based Monitoring and Information System (CBMIS) that provides health workers with

useful updates on the unmet needs of potential clients. The CBMIS has been instrumental in directing FP/RH efforts towards identified needs.

Sub-strategies were formulated to address these inequities. One was to bring IUD services closer to the people by scheduling regular visits to the clinics whenever needed. Second, postpartum or post-miscarriage recruitment were done to motivate clients to choose from an array of FP methods. Intervention measures like home visits were made. BHWs underwent training on competency-based family planning to equip them with basic knowledge on the different methods. Around 100 BHWs have been trained in this area.

In September 2002, the first FP orientation and counseling was held. The BHWs made use of their newfound skills in inviting prospective clients or couples, especially postpartum women or women with recent miscarriages. Right after the orientation, IUD insertions were performed for interested clients.

While the results looked promising, the CHO is currently undertaking measures to address some issues to make program strategies more effective. Some of the plans are to: make IUD kits readily available, enhance the mobility of trained RHMs, source funds for IUD insertion-related complications and assign back-up physicians for RHMs.

The CHO also plans to train an additional pool of midwives in IUD insertion and closely monitor and supervise newly-trained service providers. The team of trained RHMs will be asked to temporarily expand their coverage areas to include other barangays in the city.

Issues and Concerns

Timing of IUD insertions on postpartum and post-abortive women. For post-partum patients, IUD insertion may be done after six to eight weeks. The team does not have any experience yet on IUD insertions on patients who had a miscarriage.

Conflicts with the religious sector. There were news reports that some priests have refused to give communion to IUD acceptors. This represents a violation of the patient's right to privacy and that apparently, the church has information on IUD users. In a mountainous barangay in Bago City, a priest did not allow IUD acceptors to enter the church. Community members responded by boycotting Masses officiated by the said priest. Eventually, the priest relented and had to reconsider his stand on the matter.

A lesson learned from this experience is the importance of counseling. Couples should be advised on the various FP methods, including those advocated by the church. It must be emphasized to the couple that the final decision on the method to adopt rests upon them.

Back-up doctors for midwives. The first four midwives trained by the city have been inactive for some time but recently, they were mobilized. In spite of a refresher course, the midwives continue to be apprehensive regarding performing insertions. For this reason, they need a "back-up" physician during the initial stage.

CONCURRENT SESSION II
MAKING CBMIS WORK

Highlights of Presentations

1. Building Pillars to Support LGU Initiatives

Ms. Cristina B. Giango, R. N.
Cebu Province

In 1995, Cebu Province was one of the provinces under the LGU Performance Program of the DOH (LPP-DOH). In 1998, after the mid-year project assessment, recommendation was made to expand the service delivery coverage to the municipal level, hence, MGP was launched in 1999. The sub-grant program was first implemented in Bogo and Tabuelan in 2000 and expanded to six municipalities in 2001. To improve the delivery of health services both at the rural health units and hospital, the district health system was introduced in 2001.

With the devolution of powers and responsibilities to LGUs after the issuance of the Local Government Code of 1991, the public health sector had to contend with issues and problems, mostly in the form of funding, logistics, and resources.

Cebu districts were not spared, and local health practitioners came face to face with problems in program output. Obstacles lay in the field of data gathering that resulted in the delayed submission of reports. Moreover, the quality of the data gathered became questionable. The PHO technical staff suffered work overload. Program activities under various project components, notably SGP, MGP and ILHZ piled up, along with regular health deliverables.

Analyzing the situation, health proponents in the province concurred that there was a need for the Provincial Health Office and its technical staff to take a proactive role. Trainings were conducted for the technical and field staff with assistance from the MGP. After training, a point person was assigned to certain strategic areas under the district concept. Encouraged by the receptiveness of the RHUs with regard to strengthening systems and processes that were introduced such as the CDSS, the PHO was able to streamline its procedures and improve the quality of health services of units in the lower level –LGUs. As of the moment, the PHO management plans to train the other ILHZs on CDSS and create the PESU, Cebu Provincial Epidemiological Surveillance Unit.

Issues and Concerns

PHO/MHO roles in acting on CBMIS results. Dr. Cristina Giango clarified that it is the municipality's role to act on CBMIS findings under the sub-grant concept. The sub-grant enables the municipality to plan and implement activities. The province's role is to render technical assistance**.**

On data validation by midwives. Quarterly, the municipality submits its Form 3 and this is analyzed by the person in-charge of that area. If the data is questionable, municipal concurrence is sought for data in Form 1. Midwives are the point persons for this job.

*Discrepancies in population reporting**:** CBMIS vs National Projected Population vs GP.* LGUs are aware of such discrepancies. The CBMIS covers households. Figures obtained under the *"Garantisadong Pambata"* are usually higher than the CBMIS because Vitamin A is given to all children, transients included. So what is reported is the actual accomplishment of the municipality. For unmet needs, only the priority households are enumerated. Dr. Coly Catindig of MSH pointed out that the GP covers all persons whereas the CBMIS covers residents. But the data still have to be verified if taken from the CBMIS or any other source, including the FSHIS. In cases where two reports are made by the LGU, one from CBMIS and the other from GP, what is submitted to the CHD is the GP data, since not all barangays are accomplishing the CBMIS. The CBMIS should be maximized as an identification tool for unmet needs. In matters of performance assessment, the actual population is used.

Dr. Cawaling added that the municipality analyzes data contained in CBMIS Form 1. The province monitors the process and proceeds to planning. There is a surveillance unit in charge of monitoring. They analyze the CBMIS profiles. And when it comes to technical assistance, the PHO intervenes and assists the municipality and barangays.

Summary of Issues. Three main points were stressed: the role of program coordinators who adopt a geographical municipality in support of the local health zone and CBMIS; the importance of expanding training to improve the quality of the results of the CBMIS; and the importance of planning as part of surveillance for effective analysis.

2. BHW-Form 2: A Step Towards Improving CBMIS Data Quality
Dr. Minerva Millor
Bogo, Cebu

The municipality of Bogo found the CBMIS Form 2 as a more useful tool than the CBMIS Form 1. BHW Form 2 is basically the same except that the columns were changed from sitio to household (HH). The family profile was labeled as HH and was numbered accordingly. Then, the BHW will tally down the family profile to its corresponding HH column. The summary making was proven to be simpler, faster, and more accurate. It also resulted in easier validation and identification of households with unmet needs.

Issues and Concerns

Perception of CBMIS as an additional burden on midwives. Dr. Millor said that BHWs in her area responded in a positive way to the new format. Before, they also threatened to resign due to the tedious work. When introduced to the new form, their work became much easier. BHWs are given an allowance of P80.00 from the SGP fund.

MGP sustainability mechanisms and BHW honoraria. The Mayor included MGP in the regular budget of the municipality. The municipality is planning to grant health insurance to BHWs and personnel in the CBMIS areas as incentives. The P80.00 given to BHWs is not honoraria but in the form of meals and transportation allowances.

Disposal of data used in previous forms. Data obtained using old forms are kept as references and filed.

Ratio of 50-70 households per BHW and validity of data taken by BHWs who have not even finished grade school. The RHM, DOH Rep, and the MHO/CHO perform the validation at the end of every month. Dr. Coly Catindig of MSH offered that if there is one BHW to 200 households, it would be best to divide 200 HHs by 10, then by groups of 20. Summarize first the 20, and then add the rest of the groupings. This will be easier and more manageable than getting each and every HH.

Summary of Issues. If the new forms are used as a tool, this will in effect shorten the time for summarizing and validating the outcome of the CBMIS survey. BHWs could identify at once the households with unmet needs. They could easily plan where to focus their activities. Finally, it is the accuracy of the data that could be obtained with this tool that counts.

3. Improving Health Services through CBMIS
Dr. Angelito Umali
Pintuyan, Southern Leyte

Health service delivery mainly depends on the existing health situation of the community, which is equally dependent on updated community health information. Owing to the increasing rate of unmet needs for health services in the community, there is now a need to improve ways of gathering health information.

Problems usually arise due to the inefficient use of the gathered data for the analysis of the local health situation, the insufficiency of funds for the delivery of basic health services, and the lack of proper training of health personnel on data gathering and analysis. The intervention came when the municipality of Pintuyan was enrolled last November 2001 under the Department of Health-USAID (DOH-USAID) matching Grant Program. Health personnel were trained in the use of the Community-Based Monitoring and Information System (CBMIS), which has evolved into a major tool of the municipality in planning for health service delivery.

Strategies and activities included the establishment of a dynamic map and table to serve as a monitoring tool in each of the barangay health stations and the main health center. The maps are updated monthly. The staff meets regularly to discuss the status of unmet needs per barangay and monitor the feed-backing of services delivered.

The staff is also able to monitor the effects of the weekly barangay outreach program, Family Planning counseling, Couple's Classes, Parents Effectiveness Seminar, and house-to-house health services to households that are inaccessible to health stations. This results in the improvement of health facilities thru the use of Facility Self-Assessment Checklist (FSAC). Positive outcomes were as follows: marked improvement in program coverage rates, increased Modern CPR against traditional CPR, and improved capability of human health resources thru trainings/seminars. The RHU became "*Sentrong Sigla*" certified.

Issues and Concerns

Effectiveness of call cards. Dr. Umali said that the call cards are delivered to families by BHWs to facilitate the identification of unmet needs. BHWs, in spite of their dedication, do not receive any honoraria. Some of them have been working for almost 30 years now, many of them attending to households in inaccessible areas without compensation.

Mayor Leonardo A. Equipilag of Pintuyan, Southern Leyte mentioned that upon his assumption into office, he was encouraged to allocate a budget for BHW incentives (not honoraria) that was approved by the COA.

Cases where midwives ignore the use of call cards despite translation into local dialects. It is not the BHWs who fill up the call cards but the midwives. BHWs only bring the call cards to the households. Ms. Nancy Anoňuevo said that in her area, the call cards are a big help because the FSHIS could reveal FP drop-outs as well as those who were not followed-up for Vitamin A supplementation or immunizations. These are reflected in the call cards, a copy of which is furnished the midwives.

Acceptability of call cards among clients. Dr. Hermela Tan of Talisay said that the use of the call cards is an original innovation. With its use, a "personal touch" was made with clients. Even if the client cannot read, the BHWs or the midwives can interpret for them, sending them the message that they are important. In this way, they are encouraged to follow up on treatments and processes. Sometimes, BHWs visit clients two days before a scheduled activity to enlist maximum participation.

Dr. Norma Leano added that aside from the use of call cards, house-to-house visits are made. If the call cards are issued once or twice to the mother and she does not respond, house follow-ups are done.

Data on Forms 1 and 3 regarding pregnant women in their first trimester reported under unmet needs – if there are many women under this classification this would result in a high percentage of unmet needs. The concern is the strict definition of unmet needs. If a woman is in her first trimester of pregnancy, definitely, she is still under the TT1. In a sense, this is not an unmet need because she has responded to the first dose of TT during the first trimester. But it would still be classified under TT1. Dr. Tan explained that this is not considered an unmet need but a warning for follow-up in order for the patient to receive TT2.

Dr. Nelson La Fuente of Negros Occidental said that this is not a reporting job for the benefit of knowing. It would be better to follow up for TT2 than to be classified as met and forgotten. The primary objective of the CBMIS is to locate those who need the service. The CBMIS should be regarded as a tool for service delivery and not a gauge for unmet needs. It does not matter if there is a high unmet need but rather to solve problems at the soonest time possible.

Ms. Villa suggested that to solve this problem on paper, an asterisk could be made as a reminder for follow up on the second quarter. Nobody is prevented from making clarifications on the report.

In TT2+ Protection at Birth (PAB), there is a youngest child from 0-2 years old – maybe TT1 should not be considered as an unmet need. It can be considered as an unmet need if there is no PAB. Dr. Coly Catindig clarified that one does not get unmet needs with PAB. Protection at Birth in Form 1 does not apply to unmet needs. Definitely TT1 is an unmet need in the first trimester if the patient is TT0. If you have TT1 at first trimester, you do not have unmet need for TT2, because you already have TT1. This is a small issue because the mother in her full term of pregnancy should be given TT2 for the infant to be protected. The CBMIS was designed in the DOH program to accept that TT2+ is for pregnant women.

CONCURRENT SESSION III
IMPROVING DISEASE SURVEILLANCE

Highlights of Presentations

1. The Negros Occidental Health Surveillance System (NOCHESS)

Dr. Nadara Gendrala
Negros Occidental

Nochess was formed from the partnership between the Province and Bago City, with support from the Negros Occidental Health Information Network. Regular consultations were held with the Municipal and City Health Officers to discuss trends and issues related to the most prevalent diseases in the area.

Families in the community were thereafter advised on safety precautions to undertake that will effectively eradicate the incidence of dengue fever. Breeding sites were identified. In the end, the importance of the partnership between local governments was found to be essential in optimizing/utilizing locally available resources.

Issues and Concerns

Budgetary requirements of NOCHESS. There was no funding to begin with - the first batch of trainees was trained by MSH. There was data collection upon training. Participants were mostly nurses and other health volunteers. Time served as the only capital.

Process of laboratory confirmation. Those not confirmed by laboratories are regarded as suspects. Sadly, there are not enough laboratories. Financial help is needed in order to upgrade the laboratories. But, as much as possible, both clinical and laboratory confirmation are sought.

Challenges in implementing NOCHESS. The first challenge was the need to give up personal time. There were several challenges, e.g. the need for computers, the need to upgrade staff capabilities, etc. Health surveillance is a large area and training required the sacrifice of time.

Project funding. It was not enough to depend solely on the LGUs. The program had to be self-reliant. The MSH grant was used for training manuals and meals. The CHO of Bacolod provided the needed technical assistance.

2. Community-Based Disease Surveillance System: Information for Action

Dr. Ferdinand Mayoga
Bago City, Negros Occidental

The Community-Based Disease Surveillance System or more commonly called CDSS, is a form of pro-active response to the health problems of the community. It is a management information mechanism to help health workers assess the adequacy of preventive measures being undertaken. It enables them to use this as a basis for obtaining support from local leaders to facilitate the provision of health services.

The team was formed in November 2000. It is composed of one doctor and two nurses, who were equipped with only a limited number of office equipment. The CDSS was supported by a City Council resolution.

Barangay health workers were given training in monitoring diseases like animal bites, diarrhea, measles, tetanus, hepatitis, cholera and typhoid fever. Through the project, the LGU and its health partners learned that with minimal staff training, a CDSS can be established and operationalized, as long as there is a strong support from the people and local chief executive.

Issues and Concerns

Problems common to disease surveillance. Bago City's CDSS had the same problems faced by Nochess. The team found the need for greater dedication. It is really time-consuming since surveillance was done even on holidays.

Lack of laboratories. If laboratory confirmations could not be availed of, patients are merely considered suspects. Whenever possible, specimens are brought to hospital laboratories for confirmation.

Uniformity of case definitions of dengue. Dr. Zuasula expressed concern over the uniformity of data. A previous experience at the Vicente Sotto Memorial Hospital showed that during one of the rounds, the staff discerned the case definition of dengue. But when the data was analyzed along with the pediatric residents, the denominator used was different. Their case mortality rate varied. It turned out that there was no strict case definition of dengue and other diseases.

Dr. Mayoga remarked that this represents a big challenge to the public health system. Even nurses who know that a doctor is wrong in his diagnosis, do not

have the courage to reprimand the doctor and tell him he is wrong. It is just unthinkable. There is really a need to develop a strict case definition.

3. Community-Based Disease Surveillance System in an Inter-Local Health Zone

Dr. Fidencio Aurelia
Bayawan District Hospital, Negros Oriental

The Community-Based Disease Surveillance System or locally known as CDSS in Negros Oriental was established in order to monitor at the soonest possible time disease outbreaks, improve disease reporting, generate timely data for appropriate action, furnish health workers feedback on the effectiveness of health programs and provide local leaders with the management data to generate more support.

The initial activity was to create a surveillance team and to train the members by providing them with the necessary tools and equipment. All these were done with the appropriate backing of a resolution by the City or Municipal Council that was approved by the District Health Board.

Issues and Concerns

Mode of advocating for substantial funding. It was a matter of knowing the weakest point and playing good politics. Providers have to be technically prepared to be politically accepted so when they go to local government officials, they can acquaint LCEs with the technicalities for greater appreciation.

Sustainability of providing laboratory services for confirmation of Hepa cases. The potential problem to be encountered in setting up a disease surveillance system in the district lies in confirmatory diagnosis. Once the problem has been identified, we made an allocation for the establishment of the common health fund in the district for community-based projects. The fund can be used for the payment of confirmatory diagnosis done in laboratories outside the district.

Role of LGUs and the district. As far as the role of individual LGUs in surveillance is concerned, this is a district matter because of the need to develop technical skills. The plan is to decentralize activity to the individual LGUs to facilitate analysis, interpretation, and formulate recommendations for geographical representation. What is good about the district system is that the people themselves converge and exchange ideas on experiences regarding diseases. As a result, there is a material and verbal understanding among them.

Legislative support. The system is supported by a resolution passed by the council adopting this activity.

Form of funding. A special fund has been set aside for this activity coming from the health fund and this had prior approval from the Provincial Health Board.

CONCURRENT SESSION IV
ENHANCING PROGRAM SUSTAINABILITY

Highlights of Presentations

1. Peso for Health Program: *Piso Para sa Kalusugan*

Dr. Fidencio Aurelia
Bayawan District Hospital, Negros Oriental

The *Peso for Health Program* of the Bayawan District Hospital in Negros occidental is an innovation that date back to 1990. PESO is an acronym for "People Empowerment Saves One." The program was conceived due to the deteriorating health conditions in the municipality occasioned by changes in governance, poverty-related illnesses, and the high cost of medicines and health services. *Peso for Health* is a community-funded integrated hospital and public health service program intended to mobilize and allocate resources from within the community. The program stands out for being overseen by the health workers themselves.

The proponents of the program felt that under devolution, innovative approaches must be taken to address the problem of fragmentation. There was a need to re-integrate key players in health services. Households were encouraged to enroll in a social scheme for health, contributing an affordable PhP10.00 monthly in premiums. Various membership categories ranging from PhP1.00, PhP5.00, and PhP10.00 per month were established that allowed low-income families to gain access to health services with the barest of contribution.

To avail of the health program, members remit household fees and monthly dues that can be paid in-kind or in the form of cash or service. Alternative modes of payment such as vegetables and rootcrops, sand and gravel, bananas, and services as carpenters, plumbers, and others are acceptable. Services can be availed of from the community, municipal, district and provincial health facilities and offices. The program integrates all participants, using a multi-level approach since the foremost aim of the program is empowerment, using a bottom-up approach that fosters a sense of belonging and ownership among key players.

The members are given ID cards that entitle them to the services. Under the concept, there are no free services or from restrictions to entitlement. When a member in any category applies for admission, his or her classification carries with it an entitlement of PhP200.00 worth of medicines per year. Presently, members can avail of diagnostics, room and board, emergency transport service, and newborn screening that is not covered by the PhilHealth program.

Operating funds are sourced through a number of ways like active solicitation, membership fees from households and individuals, LGU subsidies through the common health fund, and contributions from charitable institutions like Philippine Charity Sweepstakes Office (PCSO), local and foreign organizations, and philanthropists.

The program incorporates a cost-sharing scheme among different levels of LGUs that allot an amount from their respective internal Revenue Allotment, 20% Economic Development Fund, and Human Ecological and Safety Fund. These allotments backstop the program funds pooled from the community. The program also encourages partnerships among NGAs, LGUs, NGOs, the community and other sectors in the sustainable financing of health services.

After three years of operation, the number of members enrolled in the program has grown. In the Sta. Bayabas District, 411 have availed of services. Along with curative services, proponents believe that there should be a parallel preventive and promotive activity. Services are available in the obstetrics, pediatrics, surgery and outpatient departments, including voluntary surgical sterilization procedures.

Indigency funds from the LGU's are pooled into a Common Health Fund that is managed by he District Health board, a part of which goes to the Peso program. The bulk or 75 percent of contributions comes from the people. The remaining 25 percent from participating LGUs is earmarked for the social health insurance. The fund is managed by the *Peso for Health* Committee composed of representatives from the districts.

Medical practitioners have been able to identify diabetics, asthmatics and other patients who can be enrolled in the PhilHealth indigency program with which the program interfaces. To launch similar programs, a number of requirements have to be met such as an inventory of health resources, sectoral participation, friendly legislation, GO-NGO partnerships, and inter-LGU cooperation. Managers are working on the possibility of covering non-PhilHealth members on a complementary or universal basis. Total availment to date averages about five to seven percent, but program managers intend to cover about 25 percent of the municipal population of 200,000. Out of 9,372 members currently enrolled under the program, only 400 have availed of services. As far as the critical mass is concerned, proponents are convinced that they can deliver the services offered in the package.

2. LGU Support for the Success of *Garantisadong Pambata*

Mayor Manuel Sia Que
Dulag, Leyte

This program is a legacy from the previous administration that was carried on by the present leadership since 1995. At that time, Dulag was one of the top 10 malnourished municipalities in the region. It is located in the eastern part of the provinces that faces the Pacific Ocean. A 4th class municipality, Dulag has a population of 40,085 with 45 barangays and households numbering 7,157. Health facilities include an RHU, the Dulag Municipal Infirmary, and six BHs covering a service population of 5,000 each. There are 220 active BHSs and five *Botika sa Barangay* that are all functional. The leading cause of mortality in Dulag is cardiovascular disease while the leading cause of morbidity is acute respiratory tract infection.

Today, Dulag may be considered to have dropped out of the country's list of malnourished municipalities for having reduced the number of malnourished children in 2001. The municipal government has chosen to prioritize the *Garantisadong Pambata* (GP) health program for children for many reasons. One, it was a potentially effective program that could save children's lives; two, because it is locally-owned and supported; three, it is child-oriented and parents find this important; and fourth, because the children in Dulag are perceived as future leaders who should obtain optimum health care to become successful adults. They represent a constituency that the Mayor has vowed to support. The municipal IRA is PhP28 million and local income, PhP9 million. Of this amount, almost a million has been appropriated for health services.

The GP is, moreover, a good vehicle for Vitamin A capsule supplementation and could effectively combat micronutrient malnutrition or "silent hunger". There were implementation issues to face in the beginning. Not all of the items in the GP package were supported by the DOH and Provincial Health Office and so, alternative strategies were mulled. One way was to include GP expenses in the regular budget of RHUs. Another was to access funding donors like Helen Keller International with programs that prioritized child health and nutrition.

The GP was then designed and structured as a five-year program that took off with community organizing, advocacy and IEC campaigns. Training programs for health workers were carried out. With the help of a DILG memorandum circular, the focal attention of health workers was obtained, and there was a moratorium on conventions during the annually observed GP month.

LCEs came out in full support. Energetic BHWs worked hard to achieve the full coverage of Vitamin A supplementation. The cooperation of agencies like DECS, DA, DILG, MPDO, and POPCOM was won. With the assistance from

caregivers, the municipality was able to organize a GP Task Force in all LGU levels, enabling the LGU to accomplish the vaccination of all children in Dulag. The GP advocacy is ongoing among barangay captains and other local stakeholders for the purpose of making the community the real owners the project. A municipal resolution was passed, ordering all barangay governments to include GP logistics in their budgets. For the future, Dulag hopes to allocate a separate municipal budget for the GP; implement a municipal procurement system for the program; implement a merit and recognition system for the ten most outstanding BHWs during the nutrition month; and sustain health, nutrition and education programs.

3. Sentrong Sigla Movement – Local Advocacy Project: Twin Strategies Towards Sustainability in Health

Dr. Elizabeth Sedillo
Tanjay City, Negros Oriental

Tanjay is a newly-created city in Negros Oriental where the rural health facilities serve ten catchment barangays. In August, the Rural Health Unit decided to apply for Sentrong Sigla Certification and started to mobilize available resources. Planning activities were undertaken, funded by voluntary contributions from health personnel, solicitations from local businessmen, and cooperation from members of the community in cash and in kind. Funds from previous donations were likewise utilized.

The Mayor wrote a letter of intent to join the program that was greatly welcomed. The initial cash award was spent for maintenance and other operating expenses, with the LGU granting the capital outlay for the RHU. This came in the form of GP Nutrition Center equipment, IEC equipment, provision of a Safe Motherhood Center, conduct of the Lakbay Aral, functional literacy program for BHWs, medicines and medical supplies. The Mayor also allocated funds for competency-based training for family planning and gender awareness.

Tanjay became one of the pilot municipalities for the local advocacy thrust. A fund contribution of PhP1 million from the municipal leaders supported advocacy campaigns. Other groundbreaking activities included structural improvements and the construction of feeding station, health promotion in the form of the *Pabasa sa Nutrition*, Dance for Life activities, and newborn screening. The RHU networked with NGOs in an effort to continually mobilize the community for the protection of children. Notwithstanding the strong support expressed and demonstrated by the LGU, the Municipal Health Office maintains a high level of advocacy for program sustainability by sustaining the interest of old and new donors from the GO and the NGO circle.

Clients can now enjoy a range of services at the RHU, including newborn screening in which the LGU has invested PhP100,000. The cost of this service is PhP550 but the RHU allows clients, indigents or non-indigents, to pay in a scheme convenient to them. A *hulugan* system was installed wherein parents can opt to pay weekly or monthly, depending on their capacity to pay. The community-based project will hopefully bring about a recovery of investments.

What made the twin strategies succeed were the following factors: a very supportive LCE and local officials, the strong commitment and teamwork of the health staff, technical support from the CHD, NGO collaboration, the cooperation of civil society and BHWs, and multi-agency support.

There are plans to integrate quality preventive and curative health services, institutionalize regulatory services, construct an emergency room, train paramedics, and ensure an adequate supply of medicines for the ten highest causes of morbidity. Tanjay hopes to achieve total quality improvement by providing regular health provider training, on top of installing all the support systems needed by the program. At present, the program aims to cover 30 percent of the population. The LGU has vowed to increase its level of support to enable the coverage of this percentage or 100 percent indigent population.

4. Increasing Political and Popular Support for FP/RH through Advocacy Networks

Dr. Aurora Perez
Futures Group International

The formation of Advocacy Networks in Negros Oriental was a policy project that was started in 1999 with family planning (FP) as a focus. This was precipitated by the fact that FP was an issue to which LGUs have been wary for a long time. Advocacy was needed to address the controversy. Increasing political and popular support was therefore important.

Advocacy networks are defined as organizations and individuals working together in order to achieve policy change for a specific issue. Advocacy involves certain targeted actions directed at decision makers in support of a specific policy issue. Such networks could do much to deepen the knowledge of the people and gain the respect and acceptance of communities. There was a willingness to address controversial issues like FP so that a broad range of perspectives and the sharing of resources can be made possible. Advocacy networks were likewise seen to be potentially effective in tapping the resources of civil society. Networking, aside from generating local resources, develops leadership, expands the bases of support, avoids duplication of efforts, and improves public-private sector collaboration.

The Negros Oriental FP/RH Advocacy network was organized in March 5, 2002 with 24 individuals representing 18 organizations from different civil society groups and LGUs. It vowed to promote FP-Reproductive Health programs. The network envisions a scenario wherein families are active practitioners and promoters of responsible parenthood, and where male involvement is high.

NEOFPRHAN has only accomplished baby steps but from March to May 2002, activities were undertaken to strengthen the network through the network building workshop, basic concepts analysis, and holding of an advocacy skills and development workshop. From May to June 2002, the network solicited political support by launching an advocacy campaign in coordination with the governor and mayors. From July to September, the program has succeeded in raising public awareness and soliciting political and popular support.

The lessons learned was that the empowerment of civil society groups can fill in the demands of the constituency regardless of transitions in power. By building a base of support for advocacy programs among these groups, the leadership qualities of people can be exploited to effect policy changes in local and national government.

Within a relatively short period of time, the use of public and private resources was maximized through the pooling and build-up of local expertise. The program also served to improve public-private collaboration by identifying common issues on FP/RH. Productive partnerships were formed to promote FP/RH programs and converge collective efforts.

Dr. Villapando shared a few insights on the NEOFPRHAN experience. It is an excellent model of a province-wide health system that made RHUs effectively reach out to the LCEs and gain their adherence. It bears noting, however, that the District Health System existed long before devolution. There are now six health zones in the province. The utilization of income derived from hospital operations to augment existing MOOEs has enabled these hospitals to survive the effects of devolution and cope with rising costs.

In 1882, Governor Macias issued EO 93-16 creating different health boards for hospitals, followed by an order allowing them to retain income. The amount was deposited as a Trust/Restricted Fund of the Hospital reflecting an income allotted to the hospitals. In the effect, the district health system made LCEs the administrators and managers of the health program. To assure sustainability, there has to be continuous advocacy. Dr. Sedillo added that for a project to be sustainable, it must be backed by legislation so that whoever sits in government will have no choice but to support a program that has been instituted with corresponding appropriations.

Summary of Key Points Raised

Mr. Uysingco enumerated the good points of the presentations and these are the realized values of community involvement, LCE support, and motivated health providers. To move programs toward greater sustainability, it is important for members of the community to gain ownership of the project for a long-term outlook. Networking is highly needed for complementation and convergence of services. Transitions in power can be addressed by people-centeredness.

Plenary: November 27, 2002

The second day of the Conference opened with a brief message from the Chief of USAID's Office of Population, Health, and Nutrition, Mr. Jed Meline.

Message
Mr. Jed Meline
United States Agency for International Development

Leaders who provide health care in the Visayas make a difference in this country. We provide funds but you make things happen on the ground. It is a pleasure to sponsor such a Conference. We thank MSH and the DOH for having strongly supported the health program for many years. The MGP has been around for the past eight years and has bee a success owing to the efforts of the regional health directors and the support of the mayors, governors, and health officers.

Presentations :

1. Making CBMIS Work Through BHWS
Mayor Florencio Flores, Jr.
Malaybalay City, Bukidnon

Malaybalay is the only mountain city in Northern Mindanao with a very rural system. It is divided into four district barangays with 487 active Barangay Health Workers (BHWs). The BHW to population ratio is 1:57. The BHWs serve as the spokes of the service wheel, moving community-based programs together. The City has continuously invested in the program in the form of training, continuing education, and career enrichment programs for old and new BHWs, accreditation

that entitles them to incentives and benefits from LGUs, civil service eligibility, enrollment in PhilHealth, affirmation through congresses and program reviews, uniforms at the barangay, district and city levels, allowances provided by the city and barangays, and retirement funds.

As counterpart, Malaybalay put up an amount equal to the MGP grant. In 2001, this was increased to PhP1.1M, and in 2002 to another PhP1.5M. The following were the positive results: unmet needs for childhood vaccination went down; unmet needs for tetanus toxoid vaccination and Vitamin A supplementation decreased; and unmet needs for FP went down from 2,427 to 1,625 from May to Sept 2002.

We have made the following recommendations to address prevailing issues: recruitment and training of more voluntary health workers, promotion of awareness among newly-elected barangay officials thru program orientation; BHW training on FP to generate more clients, establishment of a mini-OR at the City Health Office to widen access to VSS.

Issues and Concerns

Low ratio of BHWs to households. Recruitment of BHWs require the recommendation of *purok* officials and barangay councils. There are some who are not eager to join because it is purely a voluntary service, where the honorarium is a token of appreciation for work done. The city has been giving PhP200 per month, aside from what the barangays give to them.

Total percentage of the IRA allocated to health. Malaybalay's IRA in 1999 was PhP320M but it is now PhP360M. The City Health Office has been receiving a meager budget inclusive of professional services of about PhP7 million. When I became the mayor, the City Health Office getting PhP15M.

On BHW incentives and honoraria/ coverage of new BHWs recruited that is delimited by the Barangay Incentives Act requiring a service requirement of one year. The grant of honoraria to BHWs has not been disallowed by the Commission on Audit (COA). Upon accreditation, a BHW is entitled to receive honoraria. There is a 3-year clause of voluntary service. We understand the plight of these people who gave much of their time. The household to household surveys that they do are so intensive, and we have been utilizing the data they collect as the city MIS. They laid the grassroot studies on the household level which became the basis for planning and service delivery not only on matters of health but on general services as well. The City did not have to wait for provincial action in the grant of the incentives. Such is the strength of local autonomy.

On the grant of BHW Civil Service Eligibility as a hedge against transitions in political power. In Malaybalay City, the CSE 2nd grade does not guarantee employment. This grant has been arranged with the Civil Service Commission (CSC); five years of exemplary service can quality them for the eligibility.

In Malaybalay, VHWs who have achieved a lot are still with us, and changes do not discredit them from continuing in service. I would like to add that in the recruitment process, we stress before barangay officials that people they recommend should understand first and foremost that the essence is voluntary service performed less in the interest of the CBMIS and more in the interest of our own people in the *purok* or *sitio*. The voluntary nature of the job is never lost. To date, we are happy that they have been doing this heartily without any demands for an increase. We have granted the increase in recognition of the quantity and quality of work they have done.

Dr. Aurelia added that in a discussion with a group of federated BHWs working with the DOH Local Health Assistance Division, they were able to identify policy gaps in RA7083. One of the deliberations was on termination and retirement. It is important to take into consideration the functional age limit of a volunteer health worker, incentives, and the reasons for termination. They should not be terminated because they are rendering volunteer services. The issues are being raised to DOH for consideration.

Why only five BHWs applied for CSE. We go out of our way to ask them if they want to apply for the eligibility. Some of those who have served for more than ten years have not yet applied. When asked, they replied that they are satisfied with rendering service, and do not look forward to being employed. They have personally waived the prerogative.

BHW retirement benefits. Retirement per se has not yet been instituted by the *Sangguniang Panglungsod.* We have set up a fund but there is yet no ordinance supporting it. The City Council has put up a common fund. Neither have we prescribed a retirement age, we have one approaching the age of 70 but who remains active. We keep them, too. The City Council started to give an amount to those who have retired, regardless of the number of years they have rendered, at PhP1,000 per year of service. No one has yet retired. There are BHWs who average 15 years of service.

SSS and PhilHealth benefits for BHWs. We have made representations with the SSS representative on the enrollment of BHWs under the SSS program. We are also discussing the subject with the GSIS to include Bantay Bayan and BHWs. We will decide which of these we shall adopt for the BHWs.

2. Reorganization of the District Health System: A Response to Enhance Devolved Health Services

Governor George P. Arnaiz
Negros Oriental

A governor should be the Number One health worker in the province and in the city. The District Health System was introduced in 1983, with Executive Order 851 allowing for its formation. District health offices were established under EO119 and organized under the concept of Primary Health Care – involving preventive, promotive, and rehabilitative health care.

The Governor presented pre-and post-devolution situations: where health services were fragmented, hospital budgets lean, and LGUs, not technically and financially prepared to assume responsibilities for hospital operation. There was a devolution of manpower with no commensurate devolution of funds. This resulted in the reduction in local MOOE of about 52 percent, loss of the two-way referral system, deteriorated quality of hospital and public health services, demoralization of health personnel leading to the loss of administrative control and supervision, unbalanced implementation of Magna Carta for Health Workers, severed relations between hospitals and public health services, and shifts in the responsibility from political administration to local enterprise managers. LCEs were challenged to shift strategies.

The Province of Negros Oriental responded by issuing EO 92- 16 backed by the SP Resolution "reorganizing the District Health System." These legislations re-engineered the community hospitals in six mountainous areas of the province that are now licensed by the DOH.

In October 1992, hospitals boards were instituted in the provincial hospital and six district hospitals. These hospitals were authorized to use their income to support hospital operations. To further improve operation and maintenance, the province issued ordinances fixing the fees for provincial hospital services. Another ordinance allowed dental charges. The Mental Hospital was turned over to the provincial government. The province established a state-of-the-art provincial hospital diagnostic center and a Dialysis Center with five dialysis machines at the provincial hospital in partnership with a hospital in the US. Each of the hospitals is governed by a management board. Additionally, the province accredited visiting consultants and POG canter as co-training facility. Legal bases were established to backstop these changes.

Steps were taken to overhaul the district system through consultative conference, management training, advocacy campaigns, formulation of policies and guidelines, and strategic planning. A hector Sector Agenda Convergence Workshop and Health Summit were held.

To date, there are functional district health systems in the areas of CVGLJ, Sta. BayaBas, Binata District, SIAZAM, Mama Bata Pa and Vale Dalan sa Dacong Bulan. Each of these adopted distinct approaches like the community-based health insurance and the Botica sa Barangay.

Some of the lessons learned were as follows: LCE support is a basic and vital ingredient to the functional operation of the district health system. Cost sharing results in more resources and better accountability, and the districts can be an effective channel for monitoring, supervision, and evaluation of services delivered. On the whole, Negros Oriental undertook reorganization to address various health concerns and improve the quality of health care delivery.

Issues and Concerns

Innovative projects to consider. One is the cooperative health system already refined in Davao that can succeed when combined with the reorganized district health system. There can also be an integrated health system with cooperative health, or a tandem private-government health system. Or we can opt to venture into privatization which can be politically risky. Another is the family-led health services in the household through the production of herbal medicines, where members are taught alternative medicine under health in the family concept.

Availment of the Peso for Health card system. We do not require a card; automatically, card-bearing people are entitled to treatment in all hospitals. Dr. Aurelia pointed out that the next step is a province-wide implementation as an add-on to the PhilHealth initiative. Now, there are three district health zones implementing the Peso for Health. We will add three more to evolve a province-wide coverage.

Expansion of the PhilHealth Indigent Program instead of the Peso for Health. The province is implementing the PhilHealth program but not all the mayors are for this. We are trying our best to cover the entire province. Dr. Villapando said that the PhilHealth program targeted the enrollment of 30,000, representing about 70.4 percent of the population. Governor Arnaiz informed that the province will put up a counterpart fund for all municipalities interested to enroll indigents in the program.

Mayor Flores added that in Bukidnon, the Indigent Program is a cost-sharing scheme between the province and the municipalities that has been going on for one year. However, there is a possibility of the province withdrawing from the partnership.

How to relate with LCEs that do not prioritize health. They could be persuaded through effective lobbying with mayors and governors by strong political groups. Mayor Flores added that health workers who penetrate households are the best carriers of good news. Since most of them are women, they are the more stable voters. Mayor Aguila said that the Sanggunians should not be overlooked.

3. Establishing Inter-Local Health Systems

Hon. Daisy Avance-Fuentes
Governor, South Cotabato

Governors are managers who make sure that money put in the program should redound to the good of the people. South Cotabato is the food basket of the South located in the middle of the SOCSARGEN region. It is composed of ten municipalities and the component city of Koronadal. Population stands at 690,728 that is growing at the rate of 2.3% per annum. The tribal composition is a mix of Ilongo, Cebuano, Ilocano, Lumad, Tagalog, and Muslim.

The provincial development agenda is dictated by the rapid agri-industrialization where the provision of health services has become a priority. When health was devolved, great responsibilities were encountered. We needed to realign the role of the Provincial Health Office in a devolved era. The goal was to increase the value of human capital by improving the poor's access to quality health through improved preventive and basic curative health services.

We decided on a dual approach, defining responsibilities in facing health problems. Health programs must be developed and implemented with the communities themselves. The province's response to the growing health challenge was to develop an integrated health system. Workshops were conducted. The activities that followed were the establishment of functional integrated health systems in phases, conduct of a baseline study that revealed a severed linkage between public health and hospital services, poorly-defined roles, duplications and gaps, lack of community involvement, inactive local health boards, politics-based decision making, insufficient health financing, and inefficient use of available resources.

The integrated health system that evolved required bottom-up planning, clear mechanisms in access to health care, defined roles, resources, training, monitoring and evaluation, and elimination of politics. Preparatory activities consisted of the drafting of the policy and conceptual framework that provided a guide to systems development, conduct of consultative meetings and seminars to finalize proposals, and MOA signing between governors and mayors.

Adoption of the operational framework was followed by component activities such as first, the strengthening of the LGU health management systems involving the design of the MIS, and financial health system; second, strengthening of health referral and delivery; and third, mobilization of NGOs and POs in the communities. These led to the conceptualization of the Local Area Health Development Zone (LAHDZ), giving birth to five area health zones, each with referral hospitals.

After the LAHDZs were created, the province identified packages of services at each level of health care at the primary, district, and provincial core referral levels. Health referral protocols were established by creating a Clinical Protocol Advisory Committee that reviews all existing protocols. At the same time, we established strong linkages with the private hospital sector.

At present, we have managed to replicate good practices. The gains and benefits that were realized were the following: 91 percent of rural health facilities are SS-certified; sustaining mechanisms are done through continuous social marketing; the composition of the LAHDZs boards include mayors and members of the community; we continue to undertake continuous advocacy through radio, print, and lobbying with the executive and legislative branches of all partner LGUs.

Issues and Concerns

How Muslim and NPA factions affect the development process. The sectors have to be represented. There should be Muslim and other tribal councils with adequate representations. The New People's Army poses no problem as it is considered a part of the masses under us.

Baseline for CPR. There was a slight decline due to the thrust in Congress, but the itinerant teams are continually rendering services in the barangays. The big population problem should be faced squarely.

On Magna Carta implementation. All benefits due under the Magna Carta law was implemented. In LGU budgets, it is almost criminal for 70 percent to go to personnel services. We clarify that we should not take anything away from health. I ask employees to help in the generation of income and resources and limit things that do not matter. We only hire if necessary. We can only work if our people realize economic prosperity. I give out all benefits including transport costs.

Governor Arnaiz shared that Negros Oriental has paid all benefits except for the hazard pay. When finances improve, the hazard pay will be given. The DOH should fund benefits due the health personnel.

Mayor Flores reminded that a disparity was created between health and the other departments with the implementation of the PhilHealth capitation fund. We are trying to explain the disparities to other employees. The art of leadership requires the maintenance of balance and acceptability to all.

Governor Fuentes added that when health services were devolved, DOH decided to hold back certain funds. There should be one policy: if you believe in devolution, the national government should be able to define its role as well as we have defined our roles in the LAHDZ setting. Political will should cut down the bureaucracy.

Concurrent Sessions : November 27, 2002

CONCURRENT SESSION I
INCREASING MALE INVOLVEMENT IN FAMILY PLANNING

Highlights of Presentations

1. Voluntary Surgical Sterilization Campaign: The Maasin Experience
Dr. Teodulo Salas, Jr.
Maasin, Southern Leyte

Maasin is the only city in the province of Southern Leyte. It has a population of 73,943 and a population density of 349.61 per square kilometer. Out of its 70 barangays, 24 are listed as priority areas under the MGP. Maasin has two rural health units and one government hospital.

Voluntary surgical sterilization (VSS) was introduced because around 70% of non-FP users no longer want to have children. The CBMIS also revealed that utilization of surgical sterilization as a family planning option is still low in the area.

The City Health Office started its VSS program by training 30 BHWs on the competency-based family planning approach. Shortly after the training, the BHWs implemented a house- to-house campaign to recruit clients for VSS.

Apart from the trainings and active recruitment of FP clients, representations were also made with the City Mayor's office to solicit support for the program. The Mayor responded with a directive urging male government employees to participate in the family planning campaign. Local government resources were also made available to the organizers of the campaign. During the launching of the program in November 2002, five NSV and 23 BTL clients were listed as acceptors of these FP methods. In addition, two local surgeons were trained on NSV.

Despite the obvious initial success of the program, a number of problems were encountered. These include the unavailability of instruments, the lack of local service providers for NSV, too much dependence on the regional itinerant team relative to the scheduling of BTL services, low incentives for BHWs, bureaucratic problems in procurement, fast turnover of BHWs (especially during the election period), and issues related to the accreditation of Marie Stopes.

The Municipal Health Office intends to pursue regular advocacy, purchase three sets of NSV instruments for its RHUs and provincial hospitals, train more BHWs on FP advocacy, meet with the City Council to enlist more support for BHWs, and conduct regular NSV services.

2. NSV Campaign: Padre Burgos Experience "Uniting the Forces of Our Men"

Dr. Teodorico Esclamado
Padre Burgos, South Leyte

The Matching Grant Program was started in the Municipality of Padre Burgos, Southern Leyte in September 2001. As practiced in most partner-LGUs, the community-based management information system (CBMIS) was immediately implemented to determine the level of unmet needs for family planning. The results of the CBMIS were then used in formulating the strategies to address the gaps in the local family planning program.

Two of the prominent approaches adopted were the strengthening of capabilities of BHWs to promote FP services and the introduction of NSV as an effective FP method. The CBMIS revealed that although there has been very low utilization of surgical sterilization services, couples would like to adopt sterilization methods.

The Municipal Health Office laid down the groundwork for the advocacy campaign by contacting the various local government offices and private institutions. Apart from providing resources for the campaign, the municipal government of Padre Burgos issued a directive enjoining its male employees to actively participate in the FP program. The NSV campaign was successfully launched in November 2002, resulting in the recruitment of 13 NSV clients and the training of one local surgeon on the NSV procedure.

The initial success has inspired the MHO to aggressively pursue the program. Among the next activities it intends to conduct are the training of more BHWs, expansion of its recruitment program to the other barangays, procurement of NSV instruments and supplies, and organization and scheduling of NSV services at the RHUs.

3. Ang mga Bana sa Siazam District: Maoy Mangulo sa Pagplano sa Pamilya

Dr. Sozelun Zerrudo
Congressman Lamberto Macias Memorial Hospital, Negros Oriental

The presentation of Dr. Zerrudo focused mainly on the MGP in SIAZAM district. SIAZAM stands for the municipalities of Siaton and Zamboanguita.

The MGP in SIAZAM is the first such undertaking to be introduced at the district level. Compared to the previous initiatives, which were limited to arrangements with the municipal government, the MGP in Negros Oriental was coursed through the newly-established district health zone.

Each district health zone is composed of two municipal / city governments. Aside from the LGUs of Zamboanguita and Siaton, the SIAZAM health district was likewise composed of the district hospital, the inter-local health zone board (as the policy body), and the SIAZAM technical management committee (as the implementing arm). The district health zone is the provincial government's response to the need to integrate local health services and address the need for effective sharing and utilization of limited resources.

Immediately upon enrollment in MGP, the SIAZAM health district went into the training of its BHWs and health staff. It also conducted a facility assessment and community profiling, part of which resulted in the identification of the unmet medical needs of its clients (mother and child).

SIAZAM was able to train its BHWs on family planning. It was also able to sponsor the training on NSV of its local service providers and hold community meetings to promote the various FP methods, with special emphasis on NSV. According to Dr. Zerrudo, SIAZAM hopes to procure contraceptives with the use of pooled district health funds and establish a regular BTL and NSV schedule to better serve its clients.

4. Mobilizing Clients for No-Scalpel Vasectomy: Kabankalan City Experience

Ms. Alita Repique
Kabankalan City, Negros Occidental

Kanbankalan City is now on its third year as an MGP partner. Before its inclusion as MGP partner, there were no trained service providers on NSV and no real attempt has been made to generate clients. To remedy the situation, the City Health Office organized the training of BHWs on family planning. As expected,

the training helped a lot in increasing the number of NSV acceptors in the locality.

Prior to the introduction of NSV in Kabankalan City, an orientation was held on NSV for surgeons. An orientation on NSV counseling procedures was also conducted, and supplies were procured.

Private individuals and organizations also supported the program by providing food packs to the NSV acceptors. The food packs were meant to cover the lost income of the acceptors, most of whom are daily wage earners. It was reported that a number of prospective clients were being prevented by livelihood concerns from voluntarily submitting to NSV.

Issues and Concerns

Church's attitude towards FP. The church's strategy is to remind people during sermons that the only method that the Catholic Church recognizes and accepts is Natural FP. Since they are against artificial FP methods, the church is no longer invited to activities like NSV launchings.

Dr. Esclamado informed that there are only three barangays in the municipality with a Catholic population. Informed choice is emphasized and providers make an effort to tell the people about their poverty situation and the need to address it. They take comfort in the fact that the church leaders, though against FP, do not intervene in health activities.

FP targets. Average family size is four to five children, but the desired family size is respected. There is no fixed policy on the ideal number of children in the city.

Ms. Villa informed that unlike other countries where the number of children per couple is prescribed, the local FP policy merely states that FP should be adopted "if the couple has reached desired family size". Dr. Celia Fuentebaja, of Negros Occidental pointed out that according to a study, the fifth pregnancy is considered a health risk for the mother.

No-Scalpel Vasectomy side effects/ acceptance rate. No side effects were reported - the *vas deferens* is not responsible for erection and male sexual performance does not diminish after NSV. No reports were received on marital break-ups after surgery. NSV acceptors from Bago City gave their testimonies.

Dr. Lemuel Marasigan informed that only slight pain and swelling may be experienced after NSV. Only the sperm-carrying channel is incised and the

procedure does not affect normal hormonal processes that take place in the scrotum. The term *"kapon"* that signifies castration is a misconception and should not be associated with NSV. NSV should not be done if the client is not fully receptive. Restoration of the vas deferens is expensive and has a low rate of success. NSV does not automatically result in the complete removal of sperms in the vas deferens. It normally takes three months before remaining sperms are expelled. Couples are thus advised to continue with FP methods within the period. A sperm check should be made to ensure success.

To help patients cope with shyness especially in the event of female doctors performing NSV, the providers are advised to don caps and gowns to facilitate the operation.

Advocacy strategies/ policies of client attraction. Dr. Esclamado informed that before the launching, there was already a high level of FP awareness because BHWs took care of the promotion of methods like the SDM. Since there was difficulty in securing SDM beads, they pushed for permanent methods like the NSV.

Dr. Salas added that NSV was the method promoted because it is not as popular as BTL. Secondly, the health office had problems with Marie Stopes that functioned as the service provider for BTL. Thirdly, NSV can be done at the RHU.

Informed spousal consent on FP. Women usually accompany their husbands during the launching and actual NSV procedures. BHWs were specifically instructed to bring the spouses during orientation since the wife is the best motivator for the husband.

Recovery rate. Dr. Esclamado informed that the patient should stay home for the next 24 hours after NSV and refrain from strenuous activities. A barangay captain who underwent NSV was reported to have played basketball immediately after the operation but this should not be encouraged immediately after.

IEC strategies. Vasectomy was introduced at the same time that other FP methods were promoted. Although it is cheaper, the information campaign on vasectomy, however, was not as intense as those given for female contraception.

Summary of Issues. The lessons learned from the presentations can be summed up as follows: testimonials on the effectiveness of FP methods are helpful in convincing people, especially if respected community members are the ones giving the testimonials. Inter-sectoral participation can contribute to the program's success. However, there is a need to mobilize the BHWs, particularly in carrying out a sustained campaign; they could likewise help in debunking misconceptions on FP. Since non-support/ non-involvement of community

members is basically a product of these misconceptions, incentives should be provided to the BHWs to help them attract more acceptors. The distribution of food packs is a good strategy to address the concerns of daily wage earners who are willing to undergo sterilization but have been pre-occupied with earning their livelihood; other stakeholders must also be mobilized to expand the support base of the program.

CONCURRENT SESSION II
IMPROVING SYSTEMS AND PROCESSES

Highlights of Presentations

1. Pioneering the Establishment of Health Districts in the Province of Cebu

Mayor Rose Marie Suezo
Tuburan, Cebu

The Tuburan District Health System is co-owned by two municipalities, Tuburan and Tabuelan that teamed up to form the first Inter-Local Health Zone (ILHZ) in Cebu and the first to enroll in the MGP in the same province. The Tuburan-Tabuelan tandem is the first of its kind in Cebu wherein two municipalities joined forces to work on a common centerpiece program. The support infrastructure consists of two main health centers and one 25-bed hospital.

The focal personality behind the establishment of the district was the DOH Representative, who lobbied with the mayors of the two municipalities for support needed in setting up the district health system. This was considered the right solution to the deteriorating health situation of the people. One thing going for the Tuburan Health District was that it was a brother and sister act – the mayors of both towns being related in this way. No time was wasted in the drafting and signing of a Memorandum of Agreement in March 2002. The set-up was closely followed by enrollment in the MGP. The MGP grant fund amounting to PhP 1 million was augmented by a 25 percent or PhP250,000 counterpart funding invested by each of the two municipalities that went into a Common Health Fund.

A single plan was adopted for the entire district. The one-plan method was considered a better option because it facilitated the convergence of systems in an integrated manner. The implementation of activities indicated in the plan was done separately by the two municipalities. The management of the MGP fund, however, was undertaken for the combined district of Tabuelan and Tuburan.

Different committees were created to manage the CBMIS, CDSS, heath care financing, monitoring and evaluation, and quality assurance aspects of the program. It should be noted that the establishment of the CBMIS in the Inter-Local Health Zone was anchored on the health sector reform agenda. Workshops were conducted in June 2002 to formulate plans that were presented to the District Health Board. The first MGP release of PhP400,000 was used for setting up the CBMIS; funds that were used for the other systems came from the Common Health Fund established by the municipalities. In simple terms, various structural

mechanisms were set up, each with their respective sources of funding. For instance, Plan International shouldered most of the trainings.

There were compelling reasons behind the formation of the Inter-Local Health Zone. More than providing better health services to the constituents of the two municipalities, there was a need to ensure budgetary support for health programs and adopt an effective integrated approach toward quality health care. Some 200 BHWs were trained to conduct the household survey that is still ongoing. The data will be submitted to the provincial surveillance unit when completed.

Although barely a year has lapsed since the project started, benefits gained became quickly visible. The increased availability of resources was made possible by the establishment of the Common Health Fund. The health managers were able to improve on resource management and networking with other NGOs.

2. Harnessing LGU Program Management Capability

Dr. Paula Paz Sydiongco
CHD-Eastern Visayas

Eastern Visayas is composed of the provinces Samar and Leyte provinces where four cities are situated. The implementation of the MGP started in three of these cities in 1999. The goal was to develop the management capabilities of LGUs in the implementation of programs in health. In 2001, the program was expanded to cover 11 more LGUs and in 2002, another 13 LGUs. The challenge then, was how to increase the number of LGUs enrolled under the program while confronting issues such as poor monitoring systems, lack of manpower, and time constraints.

However, the LGU's exerted every effort to manage the program at their level. Technical persons from the CHD, city and municipal governments synchronized their monitoring activities and pooled various resources together. An effective strategy was the conduct of the Inter-LGU Program Implementation Review on a quarterly basis. The hosting of this activity was rotated among the municipal LGUs in the district that were clustered under the zonal concept.

Program reviews became hub of activities, as the analytical processes yielded vital information on gains as well as lapses in service delivery. Reviews were done on the progress of CBMIS, *Sentrong Sigla* certification of the health facilities, and the utilization of funds originating from both MGP and the LGUs. Nine program implementation reviews were conducted. The outcomes turned out to be positive. There was a sharing of expertise and ideas among the key players, which resulted in the improved monitoring and implementation of health projects, coordination among program partners, and LGU support.

Significant strides were made in the project. Among them was the adaptation of a systematic approach in the implementation of the MGP, the transfer of technologies among health personnel, stronger links between the DOH and LGUs, tapping of the expertise of the DOH field representatives, and improved recording and reporting systems.

On the matter of technical exchange among LGUs, inter-local health zones were 100 percent fully organized in Northern Samar. Western Samar was able to organize one district and is starting with another. In Southern Leyte, a team up between GTZ and the provincial government was explored. The province pro-acted by issuing executive orders in aid of the capability-building program. Resource sharing came in the form of round robin hostings of the implementation review among LGUs.

On the matter of drug requirements, a Memorandum of Agreement governs transactions between the CHD and the municipalities. MOAs with LGUs are not forged unless drugs are made available under the 25 percent LGU counterparting agreement. Starting in 2003, the region requires LGUs to organize the District Health Boards prior to the provision of funds.

3. Parallel Drug Importation

Dr. Jarvis Punzalan
PHO, Capiz

The Parallel Drug Importation (PDI) Scheme of Capiz began when the province was chosen as the pilot area for the health passport program. The concept of the health passport was based on universal health insurance. The idea came about due to problems encountered by health providers in pharmaceutical supply. The constituents, in particular the indigents, felt that their PhilHealth ID cards were useless whenever they went to the hospitals and found the pharmacy. They usually turned to the mayors who shared their belief that PhilHealth was an ineffective program.

When the parallel drug importation was introduced, it was intended solely for the benefit of national hospitals. When Management Sciences for Health broke ground in the locality, proponents were informed that it was possible for an LGU to embark on the scheme. The provincial government decided to go for it.

The program was presented to the governor in March 2001. Through the scheme, cheap medicines could be accessed. Initially, only four drugs were drawn to serve the needs of patients afflicted with hypertension, diabetes, and asthma. The governor allocated a budgetery support of PhP1 million that was used for the purchase of the first stocks. The purchase of cheap medicines was acceptable but

the opportunity presented two possible options: Should the affordable medicines be put on sale or given away?

If put on sale, the scheme will greatly influence local drug prices in the long run. If given out for free to support the needs of medical missions and health center clients, this will have no long-term effect on drug prices outside the service.

Four drugs, namely Nifedipine Adalat for hypertension, Glibenclamide Daonil for diabetes, Cotrmoxazole Bactrim for infections, Salbutamol inhaler for asthma were purchased. These drugs were placed in all hospitals pharmacies in the province and intended for sale to clients in the five health zones. The drugs were intended for sale.

The program did not require massive advertising; the only marketing strategy adopted was word-of-mouth and a few radio guestings. In reaction, medical representatives tried to spread ugly rumors that the cheap medicines were bad but the provincial government weathered it out. An advocate showed up in one medical practitioner who was willing to support the program. Doctors can vouch for the efficacy of PDI drugs with medical associations and colleges anytime.

The significant price discount prodded many patients to shift from drugstore purchase of maintenance medications to PDI. With the backing of experience, the province was able to negotiate with a multinational pharmaceutical firm to lower their selling price for drugs. The guidelines implemented were as follows: with a mark-up of 30 percent, the maximum number dispensed should be enough only for a month's supply for maintenance medicines.

With the PhP1 million budget, the province opened a trust account with a separate book for recording sales. Sales proceeds were deposited in the trust fund. In the case of Capiz, the provincial treasurer was directed to open the trust account for the province for the purpose of maintaining the sales proceeds. The sale of drugs in a district hospital and the corresponding receipts to be issued will depend on the policy of the provincial treasury if the fund will not be remitted to the province. The accounting department must be consulted on this matter.

The PDI Survey reviewed 110 prescriptions. Forty percent of the prescriptions came from private doctors and 59.2 percent from government physicians. Clients first heard about these medicines 53 percent from doctors, 23 percent over the radio, and 21 percent from friends. Savings were computed to be in the total of PhP 7.201 million for eight drugs. The trust fund that continues to revolve now amounts to PhP 1.5 M. The purchase has been scaled up to the present ten drugs, and the income from the sales are used to procure other drugs.

The advantage of this program was that it shot two birds with one stone: one, having a product, even private doctors will support, and two, putting cheaper

drugs on the market. It is a stop-gap measure but it is benefiting the people in Capiz in terms of putting into their hands cheap medicines that they need and that their doctors trust. Until such time that government is able to fix generics, the program can suffice for the time being.

For the benefit of those wishing to replicate the Capiz experience, the Department of Trade and Industry has an importing arm called the PITC that is open to any province or municipality. Orders are coursed thru this agency. A point of concern, however, is quantity. PITC can process orders only of up to PhP20,000 per order. Capiz' procurements range from 200,000 to 300,000.

Discussions

Dr. Rodriguez explained that income from drug sales is not as much a legal issue as coming up with an agreement with the province. The question is whether the hospital can keep the money invested by the municipalities. The province has the authority to allow that arrangement. It merely requires the opening of a Trust Account for the exclusive use of a revolving fund for the purchase of drugs and medicines, since this will benefit the hospitals. Governors will not pose any objection. Any income accruing to the fund may be kept to continue sustaining the program. They should get in touch with governors and draft an agreement beneficial to all concerned.

Summary of Key Points Raised

The foregoing presentations have shown that collaboration for quality service delivery is operative between two LGUs, between two larger organizations, LGUs and DOH. An innovative drug procurement system can be implemented at the LGU level. Certain elements that were observed were good leadership and common goals and vision in collaborative practices. Coordination was aided by consultations, dialogues in pre-planning, implementation, and monitoring. This was especially true for eight LGUs working together under a common plan.

As to collaborative undertaking within a common sector, there is an element of healthy competition among stakeholders, resulting in excellent outcomes. Value should likewise be given to the importance of pooling resources. LCEs, stakeholders, and health providers have the unique ability to face new challenges in the exploration of innovations and strategies for the delivery of quality health services to the people.

CONCURRENT SESSION III
MANAGING DISEASE OUTBREAKS

Highlights of Presentations

1. Dengue Fever Outbreak

Dr. Juanito Zuasula, Jr.
CHD-Central Visayas

In August 2002, the Regional Epidemiology Surveillance Unit (RESU) noted a rise in the number of Dengue Hemorrhagic Fever (DHF) admitted cases from Daan Bantayan, Cebu. Most of these were from Barangay Tapilon. The RESU 7 staff immediately informed the PHO and LGU of Daan Bantayan through the DOH Representative about the situation. A team from RESU 7 went to the area to assist the LGU in the investigation and control of the outbreak. A total of 13 cases were identified. Most were female children. Two died due to hemorrhagic shock.

To control the outbreak, the PHO team performed chemical fogging around Barangay Tapilon. IEC was intensified and a clean-up drive was initiated. Sustained clean-up drives were suggested to the LGU. On follow-up, cases were still noted. RESU 7 intends to inform the LGU of Daan Bantayan to reassess prevention and control methods.

Issues and Concerns

Number of cases required for the declaration of an outbreak. To consider the occurrence of infectious diseases as an outbreak, there should be comparative estimates. Records of admissions in the barangay health station may be reviewed. If a certain disease is a new one, even one case in an area is considered an outbreak - a confirmed anthrax in an area is considered an outbreak. DHF is a special case, there are color codes for this. A green label is used if there are less than two cases, yellow if there are three or more cases. Green is considered an outbreak and yellow, a hot spot, meaning it has exceeded the number of expected cases of DHF in that area. It is really a case-to-case basis. But the bottom line is you have to compare it with previous cases. If one wishes to know the statistics as far as the notifiable diseases are concerned in Negros Oriental, one could always inquire from the PHO.

The current activities in the region as far as the control and prevention of DHF is concerned are as follows. Several trainings were held on the national campaign - one is a barangay to barangay national campaign on Community-Based Vector Surveillance System called the *"Puksain Public Enemy No. 1 Dengue"*. Activities include the identification of high-risk areas by identifying natural and artificial breeding sites and the presence of DHF cases. If these are present, then it is considered a high-risk area. This is followed by the Phase I entomological survey and the surveillance of mosquito and larva sites. Surveillance is a continuing process because the DOH felt that previous case tallies merely reflected the failure of prevention. There should be total community commitment.

Identification of specific breeding sites. Dr. Zuasula explained that the outbreak of dengue entails an entomological survey requiring the services of an entomological team to identify an adult mosquito and the larva breeding sites. When trends increase, calling for such a team could entail a long process. An epidemiological investigation was instead launched involving a simple ocular inspection. It would have been very helpful if an entomological investigation was conducted to specifically identify larva breeding sites such as bamboo stubs, axil plants, and artificial containers. As we all know, garbage disposal is very poor with the compounding of plastics.

In Tanay that registered positive cases of different infectious diseases, the ovi trap surveillance has been implemented that would not only be specific for dengue but also for other vectors carrying other infectious diseases.

Medicinal plant discovery for dengue. A randomized clinical study done by the DOST few years ago revealed that the *"bangagao"* plant does not possess any claimed therapeutic use.

Precautionary measures for dengue. Thailand is currently doing a community clinical trial on a vaccine against dengue. But no final paper was yet published. And the results are not very encouraging. So a community effort in environmental awareness should be sustained to prevent the outbreak. It has to start with the local government.

2. Investigating a Hepatitis A Outbreak

Dr. Jacqueline Borja-Valencia
Basay, Negros Oriental

In July 2002, a team from the City Epidemiology and Surveillance Unit (CESU) confirmed the occurrence of an outbreak of Hepatitis A in Basay. Although an analytical investigative process would have pointed the source of the outbreak

more clearly, the descriptive method used by the group was able to identify risk factors that might have aided the spread of the disease in the community.

Undeniably, the lack of safe water supply, poor hygienic practices of residents, the absence of a waste disposal system, and the presence of questionable food sources are all parts of the cycle of the viral spread.

While in the area, the team gave support treatment to symptomatic cases. The community was assembled and an impromptu information and health education lecture was done. Personal hygiene and the importance of water sterilization through boiling were emphasized. A food handler's class was also conducted. A clean-up drive through the barangay officials was initiated.

A forum was held attended by the local chief executives, health personnel and private physicians. It was proposed that local private physicians be oriented and included in the CDSS. On follow up, routine analysis of CDSS data showed decreasing incidence of Hepatitis cases in Barangay Mannihon. Funds were already allocated for latrine construction. A resolution on barangay solid waste disposal system has already been passed.

Issues and Concerns

Control of unregulated food vendors. This continues to be a problem. The team has yet to follow up closely on the recommendation to control the increasing number of food vendors. There is a plan to give them licenses but no action has so far been made.

Difference between Hepatitis A and B. Clinically, it would be difficult to differentiate the two as they have similar signs and symptoms. This can be confirmed by laboratory testing.

Laboratory results on blood samples from two vendors. The two were found to be positive for Hepatitis A, and both were likewise victims.

3. Linking Disease Surveillance Systems: Shared Information, Shared Responsibilities
Ms. Ceander Rosquillo, RN
Bago City, Negros Occidental

This presentation showed how two disease surveillance systems, one city-based and the other, province-based, can work in synergy, pick-up cases, detect outbreaks and manage them.

The Community-Based Disease Surveillance System (CDSS) was set up in Bago City, Negros Occidental to track the occurrence of common and preventable diseases and enable health providers to institute appropriate and timely disease control measures. Active collection is done two times a week at the BHSs to analyze weekly disease trends as well as foresee geographical distribution by spot mapping reported cases. Deaths from measles outbreak were reported from Barangay Ma-ao, Bago City. This was learned in Bago City and counterchecked with the Negros Occidental Surveillance System.

There were also cases of measles in Amontay, Binalbagan, which occurred during the second week of October and continued through the first week of November. The team conducted case investigation to establish the presence of the outbreak and its possible cause.

In response, a massive health education campaign on measles management was conducted among affected families and in nearby schools. Cases were examined and supportive treatment and care were given. Health providers also gave Vitamin A capsules and anti-measles immunization among patients and children in nearby barangays. Cases with complications were referred to the Himamaylan District Hospital for subsequent treatment and curative care.

Issues and Concerns

Feedback on ring immunization. Nearby barangays in the cited area would be included in the ring. Mostly the areas are characterized by steep hills and mountains and may be very difficult to reach. For this reason, the immunization status of the barangay is low. Residents have to walk for four hours to reach the BHS. As a result, mothers do not submit their children for immunization due to the distance and the belief that immunization would make them sick.

The need for patient calls/ household visits. It is hard for the midwives to go to the area because of the character of the terrain. But they know their shortfalls.

They do go to the households but only on the first week of the month. They were instructed to make themselves available at all times.

Incidence of measles in adults. There are adult cases but most of the cases occur in childhood. IEC campaigns were sufficiently conducted in the area.

CONCURRENT SESSION IV
STRENGTHENING COLLABORATION AND NETWORKING

Highlights of Presentations

1. Strengthening the Referral System for Voluntary Sterilization: Sta. Bayabas District Health System
Dr. Fidencio Aurelia
Bayawan District Hospital, Negros Oriental

The district offers a range of services including an ambulance in case of emergencies. The Referral System is a great help in coordinating with the community and local officials. In a nutshell, the system is a good starting point to respond to many unmet needs.

Issues and Concerns

Identification of areas to be strengthened. A committee was created to oversee the referral system. The barangays are visited and assessed utilizing self-designed monitoring tools - one is technical and the other, administrative. In the case of administrative concerns, the LGU support mechanisms are identified. Another approach is conferring with barangay health workers who are in the best position to assess local situations.

Incorporation of client satisfaction in the levels of implementation. If patients cannot be provided with total satisfaction,n then they have to be referred to another health care facility that may provide the satisfaction they seek. Local government officials should understand the importance of a referral system. Ambulances are needed and so are equipment.

Logical next step when trained providers leave. Previously, there were trained doctors for BTL, etc. Since most of them have left, various ways of keeping them around are being considered.

Need for the training curriculum to be tied up with the residency training of doctors. Unfortunately, after spending for the training, doctors and other health providers do not practice the teachings upon their return to their respective areas.

2. Lessons Learned in Providing Technical Assistance

Dr. Pilar Mabasa
Bago City, Negros Occidental

The conventional way of transferring skills, introducing new interventions or replicating best practices is for the national government to provide technical assistance to LGUs. In this traditional model, the LGUs depend on trainers from the national government for enhancing the skills of local health staff.

The limited experience in the area of LGU to LGU technical exchange shows that there are many LGUs that are interested in learning, developing and adopting other LGUs' initiatives as their own programs. Even the smallest and the poorest LGU have lessons to share and stories to tell.

Bago City is one of the 12 components cities of Negros Occidental. The city enrolled in the MGP in 1999 and was one of the pioneers in the MGP program. The implementation of MGP helped the city improve the delivery and utilization of four health programs, mainly family planning, immunization, Vitamin A supplementation, and tetanus toxoid vaccination. In addition, the City Health Office availed of additional training and technical assistance on CBMIS, BHW Competency-Based Training on Family Planning, establishing No-Scalpel Vasectomy services, and the CDSS.

Being a pioneer in MGP, Bago was among the first LGUs that trained on CBMIS in 2000. CBMIS is a tool used in identifying families with unmet needs in the four priority programs under MGP. As the MGP expanded to other LGUs, the demand for CBMIS training was such that the CHO was requested to provide technical assistance to the Provincial Health Offices of Guimaras and Negros Occidental.

Bago City set up its CDSS unit in December 2000. The system was eventually expanded to cover the Province of Negros Occidental. The system set up in Negros Occidental is hospital-based, with the 12 provincially-owned and four private tertiary hospitals as reporting units.

On 16 March 2002, the Bago City CDSS unit, in partnership with CHD VII, conducted the Sta. Bayabas Health District of Negros Oriental composed of Bayawan City, Basay and Sta. Catalina. The idea was to make Bayawan District the hub of disease surveillance activities in Negros Oriental and its eventual expansion to cover the whole of Panay Island.

In Region VI, there were only two persons trained as trainers for the BHW Competency-Based Training on FP last April 2002. One of the trainers came

from Bago City. Bago City was made to assist the PHO conduct similar training courses in other MGP sites in Negros Occidental.

In January 2002, Bago City requested for training and the establishment of No-Scalpel Vasectomy services from EngenderHealth. The Bago City NSV team has been tapped to train a number of health personnel: one doctor from Tacloban, two from Bindoy, two from Sta Bayabas, and two from Donsol, Sorsogon and Kabankalan City, Negros Occidental.

Issues and Concerns

Training sites in Bago City. There are specific areas for the training which is well-supported by the Mayor's Office.

Training of LGU trainers is the best option rather than technical assistance, which can take ten years in the process. Sometimes there are no funds. MSH or the requesting LGUs provide the needed funds. A letter is all that is required from LGUs requesting for training.

Mr. Uysingco noted that in providing technical assistance, there is a need to create a ripple effect. Training one group after another group and so on creates a domino effect.

3. Improved Family Planning Services through Linkages

Dr. Ma. Lourdes Lampong
Ormoc City, Leyte

The family planning services in Ormoc had small beginnings. It started with a manpower of six doctors, ten nurses, 24 midwives, and 196 barangay health workers. Its health facilities are composed of one main health center, 23 barangay health stations, one government district hospital and three private hospitals.

Ormoc applied in the MGP in December 2001 with a program focusing on family planning, EPI, Vitmain A supplementation, and tetanus toxoid vaccination for pregnant women.

The main goals of the program were to improve access to FP services at the barangay level and to increase the number of family planning acceptors. The biggest support came from Pearl S. Buck International. It gave funds for training, for the improvement of facilities and the procurement of other necessary equipment. Among Ormoc's future plans are to expose the midwives further to

IUD insertion activities and to expand the package of services to non-MGP barangays.

Issues and Concerns

Ways of meeting the demands for FP services. Previously, IUD insertions were done at the City Health Office. Because that was the only center then, some patients could not come because they lived in remote barangays and did not have enough means of transportation. Now the situation has changed because the surveillance team can perform outreach activities in those areas with assistance from the Pearl S. Buck Fund. More people can now be reached because of the training.

Areas for further improvement and possible linkages. Ormoc City is fortunate to have for a partner, Pearl S. Buck, that specializes in health services and capability building. The foundation provided funding that the city was able to maximize for the production of IEC materials. The CBMIS activities are shouldered by the MGP. The Pearl Buck Director attends some meetings to gain a better grasp of the situation.

Sustainability measures in the event of donor phase-out. Health personnel were trained and the needed equipment were furnished. Local officials can provide the needed assistance for maintenance. As long as the skills are available, the health workers are empowered and can pass on their skills to others.

Advocacy for FP methods other than the IUD. In the case of bilateral tubal ligation (BTL), the acceptors are used as models. They agreed to pose for calendars and volunteered as peer counselors.

Closing Ceremonies

Closing Remarks
Dr. Jose Rodriguez
Chief of Party, Management Sciences for Health

We have just brought to a close an interesting and exciting conference. Acknowledgment is due the LCEs, the mayors who came and stayed throughout the length of the two-day Conference. It is clear that the project has stimulated their interest. We thank the various presenters who shared their experiences in the various projects that were implemented successfully. We thank the facilitators

who guided the discussions, the MSH organizers, and the participants for their active participation. The Visayas group has been participative and lively.

I urge and encourage everyone to translate the experiences and lessons shared at this Conference into equitable, better quality and effective health services to the people. On behalf of the organizers, we wished everyone a safe journey.